5 Year Strategic Plan for Calderdale and Huddersfield NHS Foundation Trust

Full 5 Year Strategic Plan

APPROVED By BOARD January 2016

Version 1.2

Commercial in confidence

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Abbreviations

A&E	Accident & Emergency	**IHI**	Institute for Healthcare Improvement
ACP	Advanced Care Practitioners	**IM&T**	Information Management & Technology
AEC	Ambulatory Emergency Care	**IMT**	Information Management Tool
AHP	Allied Health Professionals	**IP**	Implementation Plan
AHP	Allied Healthcare Practitioners	**IP**	Inpatient
ANNP	Advanced Neonatal Nurse Practitioner	**ISS**	Injury Severity Score
APNP	Advanced Paediatric Nurse Practitioner	**IT**	Information Technology
ATP	Advanced Therapist Practitioners	**ITFF**	Independent Trust Financing Facility
BAU	Business As Usual	**ITU**	Intensive Therapy Unit
CCCG	Calderdale CCG	**JHWS**	Joint Health & Wellbeing Strategy
CCG	Clinical Commissioning Group	**JSNA**	Joint Strategic Needs Assessment
CCTH	Care Closer to Home	**KPI**	Key Performance Indicator
CCU	Critical Care Unit	**LHE**	Local Health Economy
CDU	Clinical Decision Unit	**LoS**	Length of Stay
CEM	College of Emergency Medicine	**LTC**	Long Term Care
CEPOD	Confidential Enquiry into Perioperative Deaths	**LTFM**	Long Term Financial Model
CHFT	Calderdale and Huddersfield NHS Foundation Trust	**MAU**	Medical Assessment Unit
CIP	Cost Improvement Programme	**MCP**	Multi-speciality Community Provider
CNST	Clinical Negligence Scheme for Trusts	**MRI**	Magnetic Resonance Imaging
CNST	Clinical Negligence Scheme for Trusts	**MRSA**	Methicillin-resistant Staphylococcus Aureus
COSRR	Continuity of Service Risk Rating	**NCAT**	National Clinical Advisory Team
CQC	Care Quality Commission	**NHS**	National Health Service
CQUIN	Commissioning for Quality and Innovation	**NHSE**	NHS England
CRH	Calderdale Royal Hospital	**NHSLA**	National Health Service Litigation Authority
CRR	Corporate Risk Register	**NICU**	Neonatal Intensive Care Unit
CT	Computerised Tomography	**NPV**	Net Present Value
CVD	Cardio-vascular Disease	**OBC**	Outline Business Case
DH	Department of Health	**OBC**	Outline Business Case
DNA	Did Not Attend	**OOH**	Out of Home
DTOC	Delayed Transfer of Care	**OP**	Outpatient
DVT	Deep Vein Thrombosis	**PA**	Programmed Activity
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation	**PACS**	Picture Archiving and Communication System
ECC	Emergency Care Centre	**PAS**	Patient Administration System
ED	Emergency Department	**PDC**	Provider Development Committee
EIP	Equal Instalments of Principal	**PDC**	Public Dividend Capital
EM	Emergency Medicine	**PEM**	Paediatric Emergency Medicine
ENT	Ear, Nose and Throat	**PFI**	Private Finance Initiative
ESR	Erythrocyte Sedimentation Rate	**PHSO**	Parliamentary & Health Service Ombudsmen
FBC	Full Business Case	**PMO**	Project Management Office
FOT	Forecast Outturn	**PMU**	Pharmaceutical Manufacturing Unit

FSS	Families and Specialist Services	**PoD**	Point of Delivery
FT	Foundation Trust	**PWLB**	Public Works Loan Board
FTE	Full Time Equivalent	**PYLL**	Potential Years of Life Lost
FU	Follow Up	**QIPP**	Quality, Innovation, Productivity and Prevention
FY	Financial Year	**RAID**	Rapid Assessment, Interface and Discharge
FYFV	Five Year Forward View	**RCPCH**	Royal College of Paediatrics & Child Health
GBV/NBV	Gross/Net Book Value	**RTT**	Referral to Treatment
GHCCG	Greater Huddersfield CCG	**SAU**	Surgical Assessment Unit
GI	Gastrointestinal	**SCBU**	Special Care Baby Unit
GIS	Geographical Information System	**SHMI**	Summary Hospital-level Mortality Indicator
GP	General Practitioner	**SOC**	Strategic Outline Case
GRR	Governance Risk Rating	**SPC**	Special Purpose Company
HAI	Hospital Acquired Infection	**SSNAP**	Sentinel Stroke National Audit Programme
HDU	High Dependency Unit	**SWYPFT**	South West Yorkshire Partnership NHS Foundation Trust
HIS	Health Informatics Service	**T&O**	Trauma and Orthopaedic
HR	Human Resources	**The Trust**	Calderdale and Huddersfield NHS Foundation Trust
HRI	Huddersfield Royal Infirmary	**TUPE**	Transfer of Undertakings, Protection of Employment
HSMR	Hospital Standardised Mortality Ratio	**UCC**	Urgent Care Centre
I&E	Income & Expenditure	**WTE**	Whole Time Equivalent
ICU	Intensive Care Unit	**WYAAT**	West Yorkshire Association of Acute Trusts

Contents

1. Executive Summary

Introduction

CHFT is currently facing significant clinical, operational and financial challenges. Following an unplanned Continuity of Service Risk Rating (CoSRR) of 2 and an unplanned deficit of c. £2.2m at Q2 (FY15), resulting in a breach of the Trust's license in January 2015, the Trust is required to produce a robust plan to return it to improved risk rating levels and sustainability.

The main challenges currently facing the Trust are threefold:

Clinical challenges;

- The provision of dual site services is impacting on the quality of care provided to patients.
- Current configuration of services is not in line with NCAT's recommendation or the Clinical Consensus Model.
- Emergency departments do not meet Royal College recommendations / standards.
- The Trust suffers from a larger than average Hospital Standardised Mortality Ratio (HSMR).

Operational challenges;

- The Trust is not able to recruit for or retain an adequate workforce of substantive staff to meet demand.
- Provision of dual services is impacting operational performance in terms of patient pathways and workforce cover.

Financial challenges;

- The Trust reported a deficit of £6.3m in FY15 and this is forecast to rise to £20.0m in FY16.
- Provision of dual services across two sites is expensive, resulting from duplication of costs.
- Both estates are expensive to run in terms of upgrade requirements and PFI contracts.

All of the challenges above are faced in a difficult financial environment coupled with a growing and ageing population. These challenges present a compelling case for change for the Trust.

Structure of Approach

A set of 15 priority strategic initiatives have been identified to support the Trust over the next 5 years. A key component of these is hospital reconfiguration, with Calderdale Royal Hospital as the preferred option for an unplanned care site, and Huddersfield Royal Infirmary or Acre Mills as the preferred option for a planned care site.

- **The overall development of the plan has been framed by a set of strategic questions** developed by the Board.
- **An agreed list of appraisal criteria has been developed by the Trust Board, against which the options facing the Trust have been appraised.** This is in alignment with the Monitor Toolkit, and Treasury Green Book guidance.
- **These have been used by the Board to develop a shortlist of**:

- 15 priority initiatives to be taken forward over the 5 year time horizon of the plan
- 3 estate reconfiguration options to support implementation of a proposed new model of care

- **Further development, including indicative benefits and costs associated with the 15 priority initiatives have been developed to underpin the 5 year strategic plan.**
- **Application of the agreed criteria, together with a set of supporting critical success factors, has been used to determine the preferred estate reconfiguration.**
- **This plan is closely linked with proposed local health economy changes and does take into account proposed changes at Dewsbury Hospital.** However, it does not include any quantified impact from wider West Yorkshire changes, such as collaborative working and social care changes.
- **In development of its 5 year strategic plan, on assumption has been made on changes in the provider of choice for community services going forwards.**
- **At key points in the development of this 5 year plan, the Membership Council has been engaged to provide a check and challenge on the process.**
- **A key component of the strategic initiatives contained within this plan is the undertaking of more strategic alliances and closer working with other providers, including acute providers, providing the Trust with flexibility to address future challenges.**
- **The preferred estate configuration has changed since development of the Outline Business Case (OBC). Within the OBC, Huddersfield was stated as the preferred option for the unplanned care site; this has now shifted to Calderdale Royal Hospital as the preferred location for the unplanned care site.**
    - This change is primarily for financial reasons, as there is very little differential between Huddersfield or Calderdale as the unplanned care site on other grounds.
    - Use of CRH as the unplanned care site is associated with a £3.3m (nominal) annual running cost saving (in real terms) compared with HRI being the unplanned care site. These benefits are anticipated to be further enhanced by savings in capital costs and PDC dividend payments.
    - In the absence of a credible means of exiting the PFI at Calderdale, and given the financial position of the Trust, CHFT cannot support and further develop a time expired building at Huddersfield.

Criterion	Summary evaluation	Base case	CRH 'hot'	HRI 'hot'
Quality of Care	**The proposed model of care will:** ► **Support CHFT in meeting clinical standards**, irrespective of the choice of planned care site ► Support redesigned care pathways to enhance quality ► Improve the Trust's ability to provide emergency and other clinical cover ► Support cuts in avoidable admissions	X	✓	✓
Access to Care	► **Service reconfiguration will improve patient ability to access the right treatment in the right setting** ► There are no protected groups who are likely to be highly impacted by the proposed changes ► There is no material difference in average travel time impact between the two unplanned care site options ► Car parking in accordance with benchmark norms has been included in the capital estimates ► The proposed model of care is anticipated to improve patient productive time through co-location	✓	✓	✓
Value for Money	► **CRH as the unplanned care site provides the most positive movement in forecast income and expenditure** ► CRH as the unplanned care site provides the most positive I&E and cash position from the investment (reflecting the return on capital invested) ► CRH as the planned care site delivers the greatest improvement to net margin ► All options can increase income and / or decrease cost for individual service lines ► All options are forecast to need a mix of central and local funding sources	X	✓	X
Deliverability & Sustainability	► All options will require a plan to maintain high quality services ► Both reconfiguration options are estimated to have the same one-off reconfiguration cost ► All options will realise benefits within a 5 year time horizon ► **Delivery of the new model of care will support sustainability over the medium term** ► Both reconfiguration options will support improvements in staffing resilience and flexibility	X	✓	✓
Co-dependencies with other strategies	► **Both reconfiguration options are directly aligned with local health economy plans** ► Both reconfiguration options will support delivery against priorities identified in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) ► Both reconfiguration options will improve resilience through a reduction in forecast bed occupancy, and will improve recruitment and retention of workforce	X	✓	✓

Table 1: Estate options

Shortlist of Five Year Strategic Plan Initiatives

A short list of priority initiatives to support the Trust over the next 5 years has been identified. These are split into strategic and operational opportunities, and will be taken forward by agreed accountable and responsible leads within the Trust.

- **Strategic initiatives**
  - Reconfiguration of hospital services
  - Optimise 7-day working within resources
  - Optimise community service model to reduce demand on hospital incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics
  - Optimise information technology benefits
  - Reduce hospital and community demand by increasing prevention and self-care support for the population
  - MCP Vanguard - New Care Models that offer integrated community, primary and acute care
  - Develop / invest in strategic partnerships (e.g. GP Federation, voluntary sector, other organisations)
  - Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University
  - Introduce innovative finance structures that enable savings

- **Operational Initiatives**
  - Identification of service development opportunities to ensure we maximise income for the Trust
  - Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
  - Address clinical variation ensuring delivery of consistent standardised evidence based care
  - Workforce and skills planning
  - Reduce Bank & Agency use and deliver sustainable sickness absence reduction
  - Enhancing productivity of community work

Overall Expected Benefits

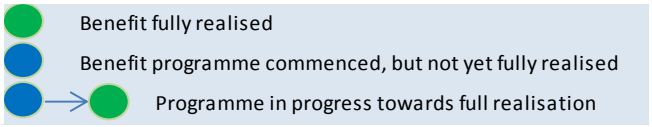
The strategic plan directly supports CHFT's strategic objectives, delivering benefits for patients, staff, the Trust and the local health economy.

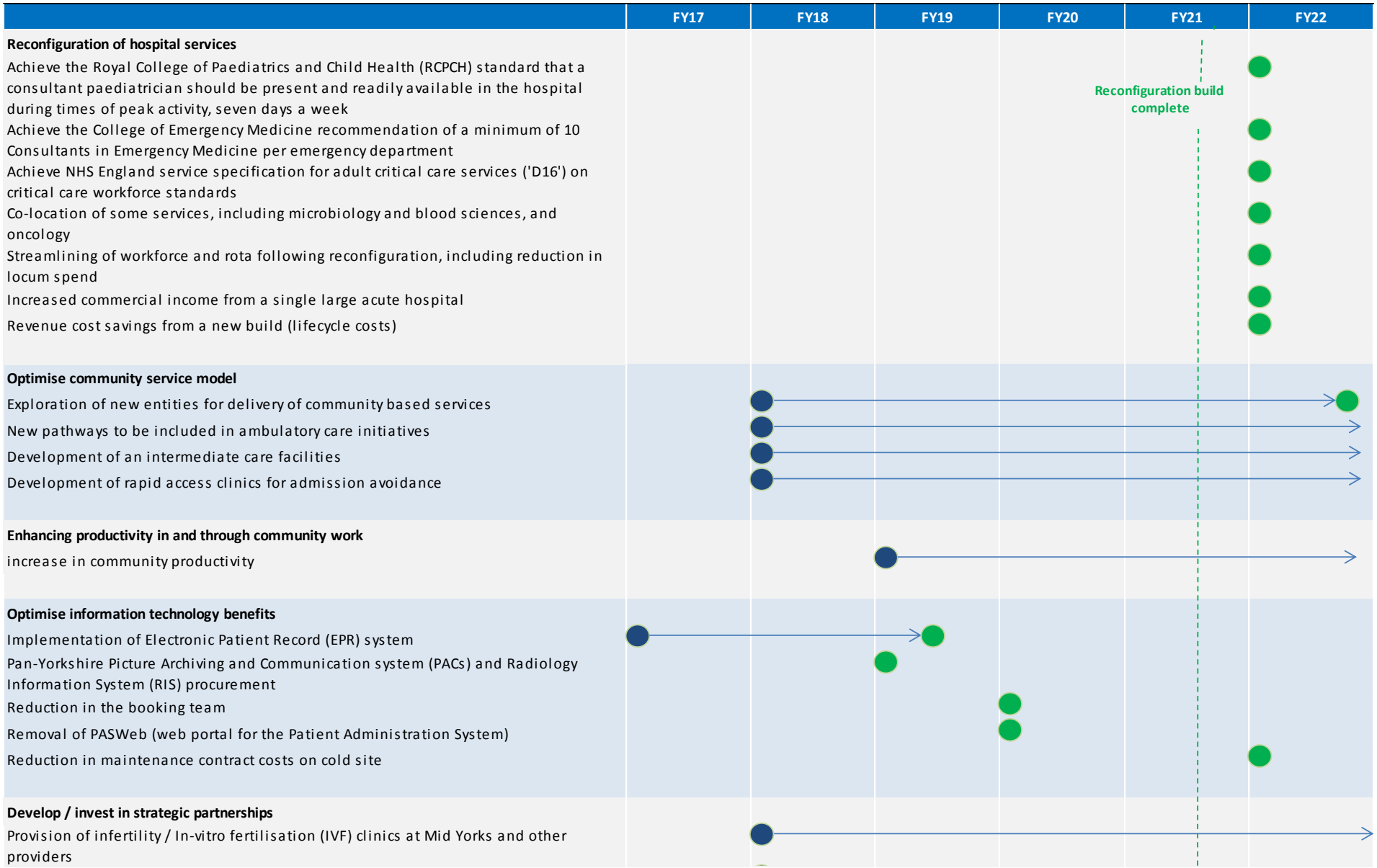
- For patients, there will be:
  - **Access to clinically sustainable unplanned care services.** The Trust will be able to meet current and expected clinical guidelines for the provision of safe and high quality services, with the ability to better provide emergency and other clinical cover.
  - **There will be reduced agency and locum use,** improving patient satisfaction.
  - **Access to a dedicated centre for planned care,** reducing cancellations and length of stay.

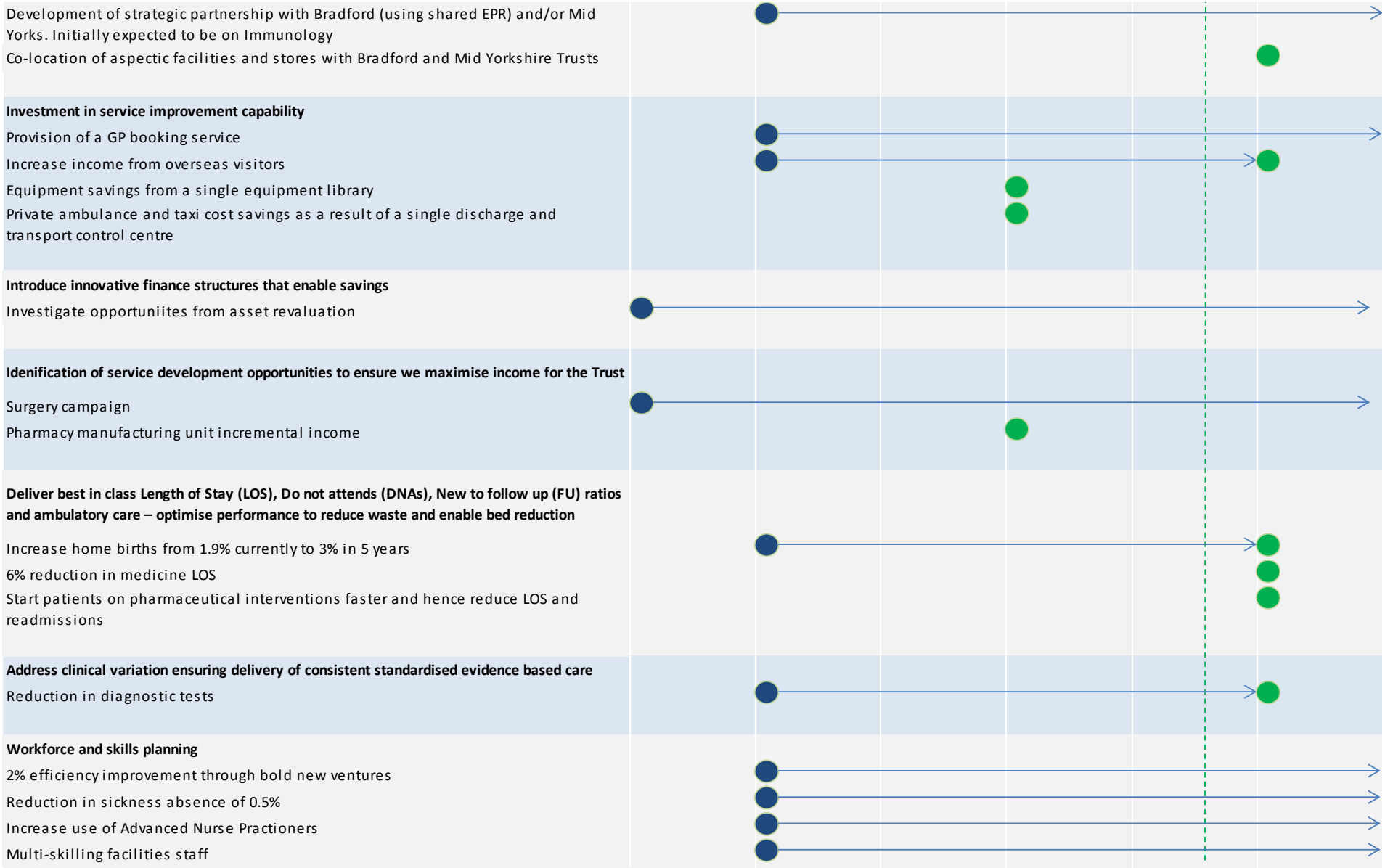
- For staff, there will be:
  - **An improvement in clinical cover and rota frequency / intensity, improving recruitment and retention** supported by a comprehensive workforce strategy. Improving staff satisfaction will mean that a more positive workforce is able to deliver better quality care.
  - **The opportunity to develop new skills, and take on new roles.**
- For the Trust, there will be:
  - **An improved financial position** through optimisation of the estate
  - **Realisation of £25.4m (nominal) in strategic annual savings across the Trust**, with further potential benefits from the clinical reconfiguration.
- For the local health economy, there will be:
  - **Redesigned care pathways** to enhance quality, reduce ED admissions and appropriately manage lengths of stay, particularly for older people.
  - **Achievement of commissioner priorities,** as the reconfiguration is well aligned with local commissioners' objectives. This includes a net reduction in the acute bed base of 77 beds, reflecting a shift of activity into a community setting.

The fifteen initiatives will enable the Trust to direct its reconfiguration and consequently improve its future sustainability. Many of these initiative activities will involve reconfiguring multiple services over many years. The table below details the proposed time frame for each initiative and the activities each initiative incorporates:

Figure 1: Expected benefits timeline




FY17
FY18
FY19
FY20
FY21
FY22
Reconfiguration of hospital services
Achieve the Royal College of Paediatrics and Child Health (RCPCH) standard that a consultant paediatrician should be present and readily available in the hospital during times of peak activity, seven days a week
Achieve the College of Emergency Medicine recommendation of a minimum of 10 Consultants in Emergency Medicine per emergency department
Achieve NHS England service specification for adult critical care services ('D16') on critical care workforce standards
Co-location of some services, including microbiology and blood sciences, and oncology
Streamlining of workforce and rota following reconfiguration, including reduction in locum spend
Increased commercial income from a single large acute hospital
Revenue cost savings from a new build (lifecycle costs)
Reconfiguration build complete
Optimise community service model
Exploration of new entities for delivery of community based services
New pathways to be included in ambulatory care initiatives
Development of an intermediate care facilities
Development of rapid access clinics for admission avoidance
Enhancing productivity in and through community work
increase in community productivity
Optimise information technology benefits
Implementation of Electronic Patient Record (EPR) system
Pan-Yorkshire Picture Archiving and Communication system (PACs) and Radiology Information System (RIS) procurement
Reduction in the booking team
Removal of PASWeb (web portal for the Patient Administration System)
Reduction in maintenance contract costs on cold site
Develop / invest in strategic partnerships
Provision of infertility / In-vitro fertilisation (IVF) clinics at Mid Yorks and other providers


Development of strategic partnership with Bradford (using shared EPR) and/or Mid Yorks. Initially expected to be on Immunology
Co-location of aspectic facilities and stores with Bradford and Mid Yorkshire Trusts
Investment in service improvement capability
Provision of a GP booking service
Increase income from overseas visitors
Equipment savings from a single equipment library
Private ambulance and taxi cost savings as a result of a single discharge and transport control centre
Introduce innovative finance structures that enable savings
Investigate opportuniites from asset revaluation
Idenification of service development opportunities to ensure we maximise income for the Trust
Surgery campaign
Pharmacy manufacturing unit incremental income
Deliver best in class Length of Stay (LOS), Do not attends (DNAs), New to follow up (FU) ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
Increase home births from 1.9% currently to 3% in 5 years
6% reduction in medicine LOS
Start patients on pharmaceutical interventions faster and hence reduce LOS and readmissions
Address clinical variation ensuring delivery of consistent standardised evidence based care
Reduction in diagnostic tests
Workforce and skills planning
2% efficiency improvement through bold new ventures
Reduction in sickness absence of 0.5%
Increase use of Advanced Nurse Practioners
Multi-skilling facilities staff

Timeline for Implementation

A high level timeline for implementation has been developed over the 5 years to FY22, with key delivery milestones, covering both the proposed service reconfiguration and priority initiatives.

- **The high level timeline is primarily dictated by the proposed service reconfiguration.** This assumes:
  - Completion of Commissioner led consultation in Q2 of FY17
  - Completion of planning and design by Q1 of FY18
  - Contract award for the build by the end of Q4 of FY18
  - Completion of the build by Q4 of FY21
  - In parallel with this, all divisions will be undertaking preparatory steps ready for go-live
- **In addition to service reconfiguration, there are a number of more immediate initiatives to be taken forward.** These are primarily associated with improving efficiency and/or reducing cost.
- **Successful delivery against the timeline will be provided through two core governance structures – one internally facing and one externally facing**. Internally, a dedicated Programme Director and Programme Board are proposed, reporting in to the Trust Board to deliver the 15 priority initiatives. Externally, a Joint Working Group will ensure alignment between the Trust, commissioners, regulators, local authorities and other providers**.**
- **This high level timeline has been developed bottom-up from milestones developed by each division** and captured in the implementation plan, and division specific Gantt charts.

CIP Delivery

The Trust is expecting to outperform CIP targets for FY16 and has made strong progress in identifying CIP plans for FY17.

- **The Trust is expecting to deliver £17.6m of savings in FY16** against a revised target of £17.2m.
- **£13.9m of schemes have been identified for FY17,** with ongoing work to identify further saving opportunities.
- **In aggregate the Trust will need to make £54.4m of CIP savings in addition to the £25.4m of strategic savings between FY17 and FY22** (nominal).
- **The Trust has an established governance process** with executive sponsorship of each of the schemes and dedicated PMO support.

Clinical Case

There is a compelling opportunity to implement a clinical model of care that will enhance delivery of acute services in accordance with best practice standards for care and patient experience.

- **The Trust is not able to provide a sustainable clinical model of provision across two Emergency Departments (EDs). This impacts on the safety and outcomes that can be achieved.**
  - The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per department. Currently there are 5 in Halifax and 5 in Huddersfield – two Emergency Care Departments within a distance of less than 5 miles.
  - The two EDs in Halifax and Huddersfield require a rota of 12 speciality doctors. In the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locum staff.
  - The Trust's high level of concern with regards to continued delivery of services has resulted in the Trust developing a contingency plan should there be an urgent need to temporarily close one of the ED sites. This has been shared with local CCGs, overview and scrutiny committees and Monitor.

- **The Trust is not currently able to substantively recruit to meet the rotas of the two sites.**
  - A number of recruitment processes have failed due to lack of applicants. The turnover of medical staff in the Trust is increasing with Consultant staff exiting the Trust in Emergency Medicine and other Medical specialties.
  - The reason given for their departure is the current configuration of Trust services across two sites. This compromises the quality of care that can be provided, and impacts on workload and frequency of on-call responsibilities i.e. a 1:5 consultant on-call commitment in Medicine and Emergency Medicine.
- **The Trust is not compliant with many standards for Children and Young People in Emergency Care settings.**
  - Currently the two Emergency Departments at Halifax and Huddersfield are non-compliant with many of the standards as described in standards for Children and Young People in Emergency Care settings. A particular challenge at present includes ensuring a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.
- **The Trust's HSMR and SHMI are above the national average.**
  - The Trust will be able to improve clinical safety by addressing dual site working (for example, through reducing the need for medical transfers and through reducing medical outliers).
- **As part of a whole system approach, a clinical model underpinning the future model of care for hospital services in Calderdale and Greater Huddersfield has been developed.** The proposed model of care would address the sustainability issues above, strengthening the care and quality received by patients.
- **This model of care proposes co-location of planned care services, and unplanned care services.** There is strong evidence that the proposed model of care will deliver clinical benefits. In particular, through improvements in paediatrics, emergency medicine and critical

care staffing, as well as more general quality benefits from service co-location. This model has also been endorsed by the Yorkshire and Humber Clinical Senate.

- **No degradation of any existing services is anticipated as a result of the proposed model**. Some services may change the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model.
- **A set of modelling assumptions has been developed by the Trust to evaluate the capacity required by the Clinical Model.** These assumptions imply that:
  - Depending on the site option, a total bed base requirement of 732-734 beds after 5 years is required (608-612 on the unplanned care site and 119 - 126 on the planned care site).
  - A total theatre requirement of 18 theatres after 5 years is required (8 on the unplanned care site, and 10 on the planned care site).
  - That reconfiguration will have a modest, but material, impact on neighbouring providers.
- **Crucially, the bed capacity on the unplanned care site is strongly linked to the delivery of significant reductions in non-elective medical demand – equivalent to 6% per annum.** This is reliant on CCGs leading development of innovative and effective models of care closer to home. Failure to achieve this runs the risk of the hospital having insufficient capacity to support demand.

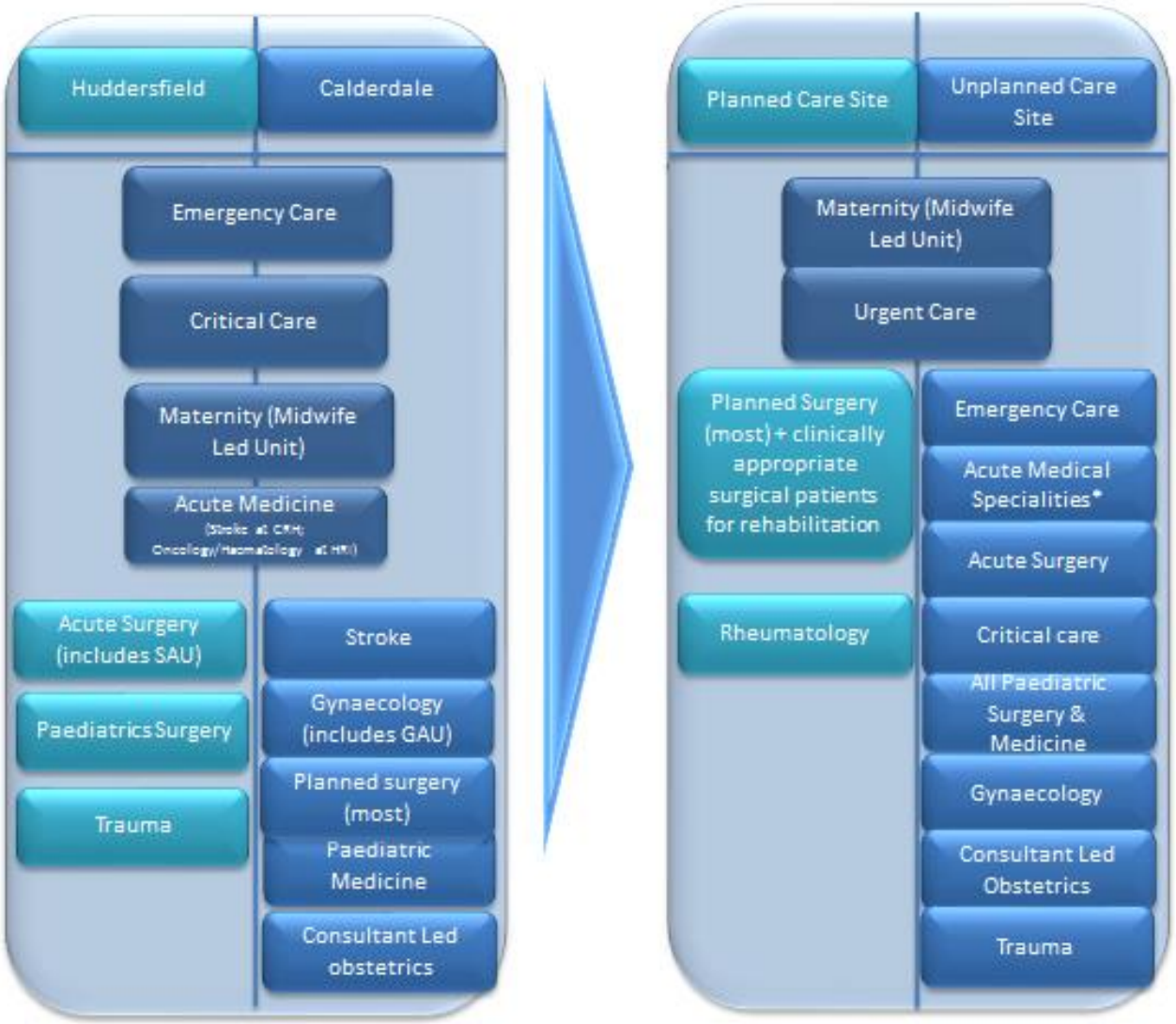


Figure 2: Current vs Future configuration of services across the Trust.

** Including Cardiology, Respiratory, Gastroenterology, Acute Stroke, Elderly Complex Care, Orthogeriatric care, Oncology and Haematology Services*

Financial Case

The preferred option yields a recurrent deficit of £9.5m from FY22 onwards. Whilst this represents an improvement of £18.0m against the Base Case deficit of £27.5m in FY22 (including strategic initiatives, but excluding reconfiguration savings), this option does not return the Trust to a breakeven or surplus position over the forecast period.

Key assumptions and findings relating to the preferred options include:

- **1-2% annual activity growth.** Non-elective growth has been assumed at c. 1%. Any variation from this will need to be managed at a health economy level through additional Commissioner QIPP.
- **Delivery of CIP targets that offset the annual efficiency requirement, equivalent to £54.4m between FY17 and FY22.**
- **Successful local health economy delivery of a 6% annual reduction in Non Elective Medical Admissions over each of the 5 years – a significant target.**
    - This has been assumed to be offset by an equal level of cost reduction within the Trust and equates to a real term reduction of c.£2.5m per annum.
- **Successful delivery of £18.0m in net recurrent annual savings from the reconfiguration, with a further £7.4m independent of the reconfiguration** (in nominal terms).
    - If HRI is the unplanned care site, the equivalent annual savings from reconfiguration are £14.7m, and non-reconfiguration related savings are £7.4m, consistent with the CRH unplanned care site option.
    - The £3.3m difference on reconfiguration savings relates to estates operating costs, whereby the full cost saving is achieved from closing HRI whilst only partial costs can be saved from closing CRH owing to the PFI arrangements.
- **Securing external funding support of £478.8m made up of**:
    - £354.8m in loan funding to support the capital requirement.
    - £9.1m in non-recurrent reconfiguration revenue costs funding.
    - £115.0m non-recurrent deficit support funding.
- **Subject to securing the external funding support as above, the Trust's income and expenditure and cash position are forecast to be sufficient to support the Trust's interest and repayment obligations.**
- **Incremental annual costs of providing an urgent care facility at a third site, such as Todmorden, are estimated at £1.2m and have not been included in any of the options.**
- **Finance assumptions have been revised for DH technical financial planning guidance published in early 2016. This has not impacted the financial option appraisal.**

£m (Nominal)	FY18	FY19	FY20	FY21	FY22
CIP	8.2	7.0	7.0	9.3	9.3
QIPP	2.8	2.7	2.6	2.5	2.4
Strategic savings	1.1	2.6	3.3	-	0.4
Total non-reconfiguration savings	**12.1**	**12.3**	**12.9**	**11.8**	**12.1**

Table 2: Summary of total non-reconfiguration savings

Capital Plan

Capital expenditure requirements ranging from £156.0m to £364.7m have been identified over the period to FY22 to support the 5 year plan.

- The size of the capital requirement is driven by three factors:
  - **The condition of the current estate at HRI**. HRI is 50 years old and requires extensive maintenance and upgrade. This is impacting patient care as there are issues with space and the age and fabric of the building. Further deferral of these costs is not considered feasible.
  - **Capital for the wider capital plan**, covering IMT infrastructure, replacement of equipment and capital to undertake essential works and maintenance.
  - **The need for capital to develop the estate to support proposed changes to the clinical model**.
- **Retaining services within the current configuration and within the current estate would require a total capital investment of £156.0m.**
  - £92.4m to upgrade time expired buildings on the HRI site.
  - £62.4m for the wider capital plan, including IMT and equipment.
  - £1.2m to support the development of the Pharmacy Manufacturing Unit (PMU) which will in turn deliver £1.0m-£1.5m of strategic savings.
- **HRI as a site for unplanned care with CRH offering planned care would require a total capital investment of £364.7m.**
  - £92.4m to upgrade time expired buildings on the HRI site.
  - £63.6m for the wider capital plan, including IMT and Pharmacy Manufacturing Unit investment.
  - £208.7m for the development of the HRI site to accommodate the unplanned care facility.
- **CRH as a site for unplanned care with a new build at HRI or Acre Mills offering planned care would require a total capital investment of £354.8m.**
  - £15.5m to clear backlog maintenance (this is significantly reduced, as some, or all, of the main HRI site is disposed of in this option).
  - £63.6m for the wider capital plan, including IMT and Pharmacy Manufacturing Unit investment.
  - £275.7m for the development of the CRH site to accommodate the unplanned care facility.
  - Note: this option includes a net £7m capital receipt for the sale of the main HRI site.

Commercial Case

CHFT's financial performance is weakening. Service and site reconfiguration presents a compelling opportunity to improve the financial and clinical sustainability of health provision for the people of Greater Huddersfield and Calderdale.

- **The Trust has poor and deteriorating financial performance.**
- **The Trust is currently clinically unsustainable.** There are a number of services that are either non-compliant or not fully compliant with current standards.
- **Reconfiguration of services represents the best option for delivering sustainable high quality health services.** Commercial benefits of this reconfiguration include:
  - **£16.0m in strategic savings opportunities** (£18.0m in nominal terms) that can be driven through implementation of an agreed clinical model.
  - **A further £6.7m of strategic savings have been identified** (£7.4m in nominal terms) that are not dependent on a site reconfiguration.
  - **Implementation of a clinical model that is strongly aligned with commissioners' intentions and the needs of the local population** - subject to consultation.
  - **A more efficient configuration of services** to improve operational efficiencies and create synergies within the hospitals.
  - **A significant investment in the local health economy –** the site reconfiguration will enable wider scale strategic changes in the way that healthcare is provided to the local population.
- **Commissioners are supportive of the proposed reconfiguration, and will make a decision on whether to commence public consultation in January 2016.**
- **There is a currently a discrepancy in forecast income of the Trust of £22.3m by FY22 between the Trust and commissioners.**
  - **This is primarily driven by differences in QIPP assumptions.** Specifically in relation to QIPP, the Trust is expecting a reduction in income of £12.4m relating to QIPP whereas commissioners are expecting £27.2m.
- **QIPP expectations and plans will be managed throughout the period to reduce avoidable non-elective admissions** through improved management of care in alternative settings.
  - The Trust and the commissioners will work together to improve patient outcomes and financially benefit the health economy as a whole. This reflects the Trust's support for more care out of hospital through QIPP.
  - A reduced QIPP value compared to commissioners' plans has been incorporated as a planning assumption to mitigate risk of under delivery and a design of a future hospital model that may have insufficient capacity.

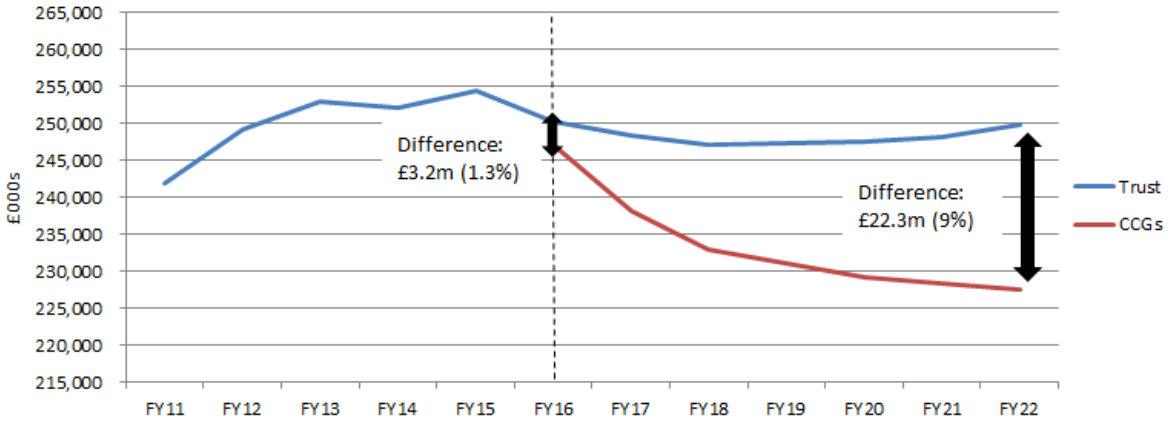


Figure 3: Comparison between Trust and Commissioners' income forecasts

Workforce Case

The Trust face considerable workforce challenges to the detriment of the resilience of clinical services, staff satisfaction and health and to the Trust finances. As such, workforce is one of the key factors driving the need for reconfiguration.

- **Workforce challenges include the following:**
  - Non-compliance with Royal College of Emergency Medicine's recommendations on Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant cover
  - Intense, fragile clinical rotas where unplanned services are provided at two sites
  - Recruitment, retention and vacancy challenges
  - Long term sickness absence challenges primarily relating to anxiety, stress and depression
  - Heavy reliance of locum staff – with £21.2m forecast expenditure for FY16
- **The challenges above arise specifically due to the current clinical service, and are addressed through the proposed reconfiguration of clinical services.**
- **Further to the reconfiguration, the Trust will employ broader strategic workforce initiatives to improve the quality and resilience of clinical services and improve opportunities for workforce, such as –** community collaboration with Pennine GP Alliance, Radiology pooling with West Yorkshire's Association of Acute Trusts, shared provision of pathology service across the patch, Primary care collaboration and integration, workforce skill mix changes and the use of technology (e.g. Telehealth and Telemedicine).
- **Staff whole time equivalents will reduce by 966 over the period (3.2% per annum)** of which 765 (79%) relates to delivering the annual efficiency requirement, 88 (9%) relates to non-configuration dependent strategic savings and 122 (12%) relates to delivering further savings associated with the proposed clinical reconfiguration – with the effects of growth and QIPP approximately offsetting one another with a net increase of five WTEs.

- **In developing the 5 year plan, the Trust's financial position is strongly constrained by CIP and QIPP requirements.** This in turn, has led to the need to develop a workforce plan to fit within this overall financial envelope.
- **It is assumed that business as usual turnover of staff, currently at 15.4%, will be sufficient to achieve the necessary reduction in WTEs without the need for redundancies.** No assumption has been made regarding re-investment in the community workforce model or the preferred provider of these services.

Type	Category	16/17	17/18	18/19	19/20	20/21	21/22	% change
Substantive	Consultant	235	238	240	245	245	242	3%
Substantive	Junior medical	310	321	329	337	348	336	8%
Substantive	Non clinical staff	1,054	1,002	950	899	854	792	(25%)
Substantive	Nursing, midwifery & health visitors - community*	294	294	294	294	294	295	0%
Substantive	Nursing, midwifery & health visitors - inpatient*	2,312	2,300	2,300	2,319	2,305	2,224	(4%)
Substantive	Scientific, therapeutic, & technical	865	821	782	744	700	657	(24%)
Substantive	General practitioners		-	-	-	-	4	-
Agency & Locum	Consultant	22	16	11	5	5	4	(82%)
Agency & Locum	Junior medical	55	45	35	19	9	8	(86%)
Agency & Locum	Non clinical staff	326	271	218	164	109	54	(83%)
Agency & Locum	Nursing, midwifery & health visitors	123	100	79	57	34	14	(89%)
Agency & Locum	Scientific, therapeutic, & technical	1	1	1	1	1	1	(13%)
Total		**5,597**	**5,409**	**5,238**	**5,084**	**4,905**	**4,631**	**(17%)**

**includes advanced practitioners*

Table 3: Configuration of workforce

Key Risks to Future Case

The Five Year Strategy is subject to a number of significant risks

- Key risks include:
  - **Failure to have sufficient capacity to meet demand.** This is likely to be due to under delivery of forecast QIPP, and/or greater than anticipated growth in non-elective demand. It would be likely to lead to significant operational, financial and clinical pressures**.**
  - **Failure to deliver savings in excess of business as usual CIP savings requirements.** There is also the risk of additional costs being incurred, particularly in relation to 7-day working requirements.
  - **Failure to reach a satisfactory agreement with the current CRH PFI provider on the proposed estate changes.** An agreement will be necessary prior to any changes to CRH being made. The current financial forecasts do not include any incremental costs which may be associated with implementation at the CRH PFI site. This will be subject of negotiations with the current PFI provider.
  - **Failure to secure the proposed capital and transitional funding.** This may make the proposed reconfiguration become unaffordable.
- **Development of mitigations to address these risks is ongoing.**
- **A comprehensive risk assessment, escalation and mitigation process is in place to support the plan**. Risks are managed centrally through the Project Team, and locally through the sub-groups reporting into the Project Team with escalation to corporate level in accordance with agreed thresholds.

2. Introduction

The purpose of this document is to describe and explain the 5 Year Strategic Plan (the Plan) that has been developed for the Calderdale and Huddersfield NHS Foundation Trust (CHFT or the Trust). The main aims of the Plan are to return the Trust to a state that is clinically and operationally sustainable for the future and to improve the Trust's financial position.

Previous to the 5 Year Plan, and upon recommendations from the Department of Health Gateway Review conducted in 2013, the Trust invited the National Clinical Advisory Team (NCAT) to review the current hospital configuration.

NCAT visited the Trust in June 2013 and following their review, recommended that the Trust develop a future service plan centred around more care, both planned and unplanned, being provided in the community, and the two hospitals having a clearer focus in terms of planned and unplanned services.

Since June 2013, the Trust has been working to improve sustainability of the Trust and has already submitted a Strategic Outline Case (SOC) which proposed an integrated care structure to provide exceptional standards of care and support that will enable optimal health at lowered system cost and an Outline Business Case (OBC) which considered reconfiguring the Trust's estate to support the integrated structure.

Both documents were developed alongside Locala Community Partnerships and South-West Yorkshire Partnerships NHS FT to address the requirements of an ageing population and the national economic situation.

The basis of the OBC suggested that emergency services should be centralised at one hospital while the other hospital would perform planned operations. The decision of which hospital should undertake which services was not agreed at the time of the OBC and was a decision that the Clinical Commissioning Groups (CCGs) were going to take following public consultation.

In August 2014, the Governing Bodies of the CCGs agreed to delay public consultation and instead agreed a phased approach to the reconfiguration of hospital services. One of the key reasons for this decision was that the CCGs wanted to ensure there was a plan to strengthen community services in the future. The CCGs would then discuss their 'readiness for consultation' in 2015. The CCGs have stated that in order to be ready for consultation, they require a proposed future model of care, the financial implications of this and the preferred location for planned and unplanned services.

Over the course of the last year the CCGs, the Trust and local health economy stakeholders have been working together to agree a clinical consensus model outlining the future provision of hospital care. On 19th October 2015, clinical consensus was reached and has been signed off by the CCG Clinical Chairs and CHFT's Medical Director. The Clinical Consensus Model has been endorsed by the Yorkshire and Humber Clinical Senate.

The stakeholders involved in model development identified nine key principles regarding the future potential clinical model design, namely:

- Deliver care locally and retain services close to home and, where possible, also bring additional services closer to home;
- Deliver services in accordance with best practice standards in relation to standards of Care and Patient Experience;

- Provide better/improved access to primary care services;
- Build resilient, sustainable services, users and communities;
- Provide a financially sustainable system;
- Are underpinned by high levels of performance and delivering World Class outcomes;
- Are planned and delivered in a joined up / integrated way across agencies;
- Maximise the use of technology to support local delivery, effective decision making and cross location working; and
- Are supported by a sustainable workforce with the right leadership, skills, values and behaviours optimising professionals working at their skill level.

Further details on the clinical consensus model are available in section 8.1 of this document.

In order to move forward and agree how to plan for implementation of the Clinical Consensus Model, the Trust and the CCGs have agreed a joint timeline and a set of actions to bring this information together into a Strategic 5 Year Plan and Implementation plan. The CCG's readiness for consultation will be tested in the New Year.

2.1 Purpose and structure of this document

This document is split into sections as per below:

Section	Description

Section 3: Structure of approach *(page 40)*	▶ Strategic questions underpinning development of the 5 Year Strategic Plan.
	▶ Approach used to develop the:
	  ▶ 15 priority initiatives included in the 5 Year Strategic Plan.
	  ▶ 3 estate reconfiguration options.
	▶ Agreed criteria and critical success factors used to determine the initiatives to include in the 5 Year Plan and preferred estate reconfiguration.

Section 4: Short list of 5 Year Strategic Plan Initiatives *(page 52)*	▶ Details of the 15 priority initiatives included in the 5 Year Strategic Plan split between strategic and operational initiatives.
Section 5: Overall expected benefits *(page 71)*	▶ The proposed time frame for each of the 15 initiatives and the activities each initiative incorporates.
Section 6: Timeline for implementation *(page 75)*	▶ A high level timeline for implementation over the 5 years to FY21 with key delivery milestones.
Section 7: CIP plans *(page 80)*	▶ Historic performance of CIP delivery. ▶ Future CIP schemes. ▶ Governance structure for CIPs.

Section	Description
Section 8: **Case for change and future case**	
Section 8.1: **Clinical case** *(page 86)*	► The clinical vision of the organisation. ► The current challenges facing the organisation in relation to the provision of clinical services. ► A summary of the Clinical Consensus Model which underpins the potential outline model of care for hospital services. ► Clinical benefits to be realised through implementation of the Clinical Consensus Model. ► Key outputs from activity modelling.
Section 8.2: **Financial case** *(page 137)*	► Forecast methodology and overview of financial assumptions. ► Forecast financial performance under each site option. ► Capital expenditure under each site option. ► Funding requirements for each site option.
Section 8.3: **Capital plan** *(page 165)*	► A listing of the capital expenditure requirements over the time horizon of the plan for the various options under consideration
Section 8.4: **Commercial case for change** *(page 180)*	► High level clinical and financial performance and the effect on the Trust's future sustainability. ► Commercial benefits associated with reconfiguration. ► Commissioner engagement.
Section 8.5: **Workforce case** *(page 190)*	► Workforce challenges. ► Strategic workforce initiatives.
Section 9: **Key risks to the future case** *(page 202)*	► Key risks associated with the 5 Year Strategic Plan. ► Mitigations to address the identified risks. ► Governance process underpinning risk management.
Section 10: **Appendices** *(page 208)*	► Supporting information.

2.2 Background and case for change

CHFT is currently facing significant clinical, operational and financial challenges. Following an unplanned Continuity of Service Risk Rating (CoSRR) of 2 and an unplanned deficit of c. £2.2m at Q2 (FY15), resulting in a breach of the Trust's license in January 2015, the Trust is required to produce a robust plan to return it to improved risk rating levels and sustainability.

The main challenges currently facing the Trust are threefold:

Clinical challenges;

- Provision of dual site services is impacting on the quality of care provided to patients
- Current configuration of services is not in line with NCAT's recommendation or the Clinical Consensus Model.
- Emergency departments do not meet Royal College recommendations / standards.
- The Trust suffers from a larger than average Hospital Standardised Mortality Ratio (HSMR).

Operational challenges;

- The Trust is not able to recruit for or retain an adequate workforce of substantive staff to meet demand.
- Provision of dual services is impacting operational performance in terms of patient pathways and workforce cover.

Financial challenges;

- The Trust reported a deficit of £6.3m in FY15 and this is forecast to rise to £20m in FY16.
- Provision of dual services across two sites is expensive, resulting from duplication of costs.
- Both estates are expensive to run in terms of upgrade requirements and PFI contracts.

All of the challenges above are faced in a difficult financial environment coupled with a growing and ageing population. These challenges present a compelling case for change for the Trust.

2.2.1 National Health Context

- **Ongoing financial challenge:** NHS Trusts throughout England are required to deliver efficiency savings of circa 3-5% per annum. Increasingly it is recognised that traditional Cost Improvement Plan (CIP) schemes alone will no longer deliver the required savings, with savings at 30 September 2015 £189m below plan[1]. Trusts will be expected to engage in wider transformational change and service reconfiguration with other agencies and providers in order to deliver the savings required to reduce deficits. The net deficit for the Foundation Trust sector was £729m for Q2 FY16, compared to a planned deficit of £560m[1].
- **Increasing operational pressures:** Trusts across England are encountering increasing demand for acute services, particularly through escalating Emergency Department (ED) attendances and unplanned admissions to hospital. An ageing population with associated long-term conditions will demand more from health care providers year-on-year.

[1] Monitor : Quarterly report on the performance of the NHS foundation trust and NHS trusts: 6 months ended 30 Sept 15

- **Increasing quality expectations:** there is ever increasing scrutiny of Trusts, hospitals, departments and individual healthcare professionals. Rolling Care Quality Commission (CQC) inspections, the Francis report, and more recently the Keogh Review, are increasing pressure to maintain high standards of care at all times, requiring significant changes to health service culture and working practices in the context of a constrained funding environment.
- **Five Year Forward View (FYFV) for the NHS in England[2]:** published in October 2014, the FYFV set out a concise vision for NHS Trusts to drive and deliver change that will benefit their local population. Whilst the FYFV recognised that the NHS had performed remarkably well despite the biggest financial challenge in its history, it set out that change was necessary due to the changing care landscape (including that long-term conditions now account for 70% of the NHS budget; technological possibilities; and ongoing budget pressures) and the need to address three growing divides:
  - The health and well-being gap, and the need to reduce the demand on the health and care system through promoting prevention and reducing avoidable illness;
  - The funding and efficiency gap, and the need to match reasonable funding and system efficiencies; and
  - The care and quality gap, and the need to embrace new care models, harness technology and establish a new deal for primary care (such as list based GP and hospital services, chains, partnerships or joint-ventures).
- **The 10 National Clinical Standards[3]:** in light of the proposed extension of NHS services to seven days a week, the NHS Services, Seven Days a Week forum recommended the adoption of 10 national clinical standards that describe the standard of urgent and emergency care that patients should expect to receive. These standards cover aspects of care such as timescales for assessing admissions; seven day access to certain services; and a care experience for patients that incorporates a fully informed, mutual decision making process about investigations, treatments and on-going care.
- **The comprehensive spending review[4]:** As announced in the 2015 autumn statement, the Government has confirmed that the NHS will receive £10billion more in real terms by 2020-21 than in 2014-15, with £6 billion available by the first year of the Spending Review.

2.2.2 Local Health Economy Context

The Trust will need to respond to anticipated changes in the demographic and health profile of the local population. Clinical commissioning groups and local authorities have drawn up Joint Strategic Needs Assessments (JSNA) which identify some common themes that drive the health needs of the local populations. For Calderdale and Greater Huddersfield these are:

- **Population growth:** The population for Kirklees is c. 434,000 and for Calderdale is c. 209,000, giving a combined population of c. 643,000 people. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037[5]; which is consistent with England's expected population growth of 14%. It should be noted that Greater Huddersfield CCG directs 82% of

[2] Five Year Forward View, October 2014, https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[3] 10 National Clinical Standards, https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf
[4] Spending review and autumn statement 2015
[5] Office of National Statistics, 2012 based subnational population projections for local authorities in England – this includes the usual resident population as at census day (27th March 2011)

their patient flow to CHFT[6]. In the case of Calderdale CCG, this is 87%[6]. There are approximately 185,000 of the Kirklees population who fall under North Kirklees CCG, who direct minimal patient flow to CHFT[7].

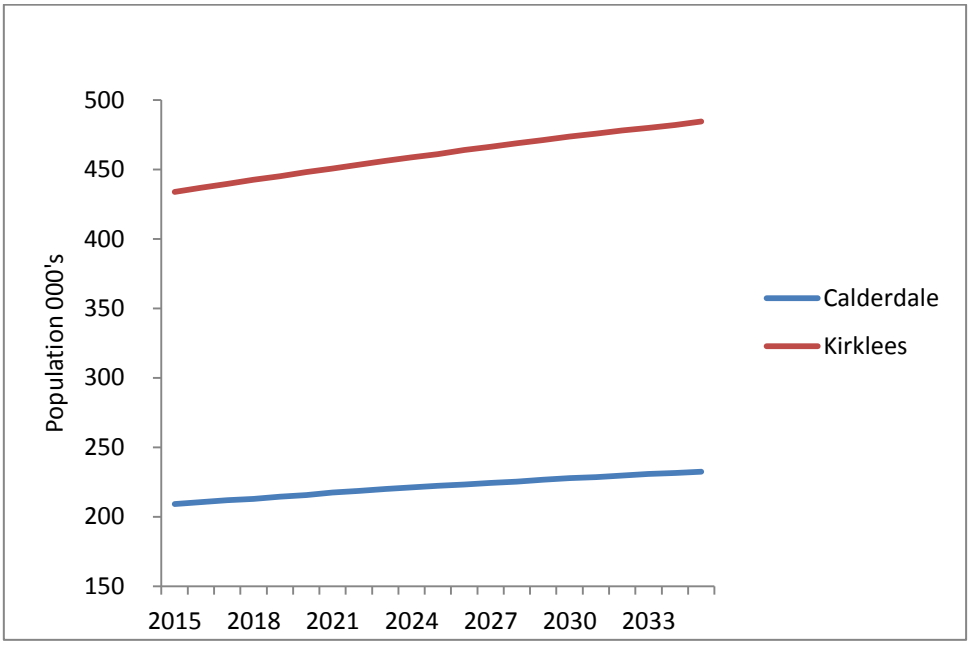


Figure 4: Forecast population in Kirklees and Calderdale. Source: Office of National Statistics, 2012 based subnational population projections for local authorities in England

- **Ageing population:** The populations of Kirklees and Calderdale are ageing: in 2012 there were 102,000 people aged 65 years and over[5] (16% of the population). This is forecast to increase to 169,000 people over the age of 65 years[5] by 2037 (23% of the population). These increases represent a compound annual growth rate of 2% for the 65 plus age group and 0.5% for the full population. This is a significant challenge, as the likelihood of having long term conditions increases with age and so does the likelihood of having multiple conditions, increasing the demand on the health system. Kirklees Joint Strategic Needs Assessment 2013 reports that by the age of 55-64, one in four people had at least one of the conditions identified in the Current Living in Kirklees 2012 survey. Additionally, by the age of 75, almost two in three had two or more conditions. In Calderdale and Kirklees it is estimated there are c.2,400 people[8] and c.4,200 people[9] respectively living with dementia. Statistics show that more people in Calderdale are admitted to long-term residential care than in other parts of the country.

[6] Greater Huddersfield CCG Annual Report 14/15
[7] North Kirklees CCG Annual Report 14/15
[8] Calderdale Joint Strategic Needs Assessment (2012)
[9] Kirklees Joint Strategic Needs Assessment (2010)

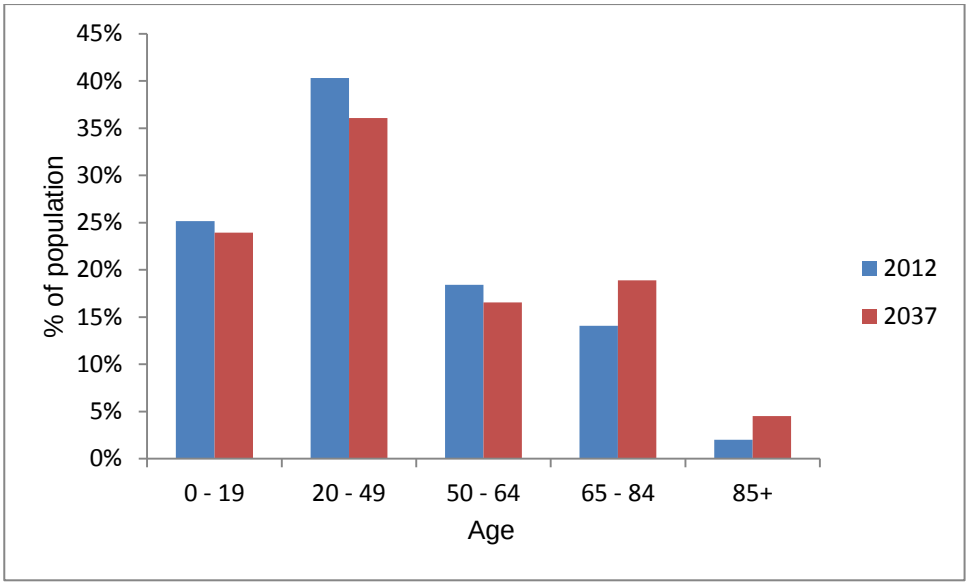


Figure 5: Forecast population ageing in Kirklees and Calderdale. Source: Office of National Statistics, 2012 based subnational population projections for local authorities in England

- **Life expectancy:** The life expectancy in Kirklees and Calderdale has increased year-on-year.

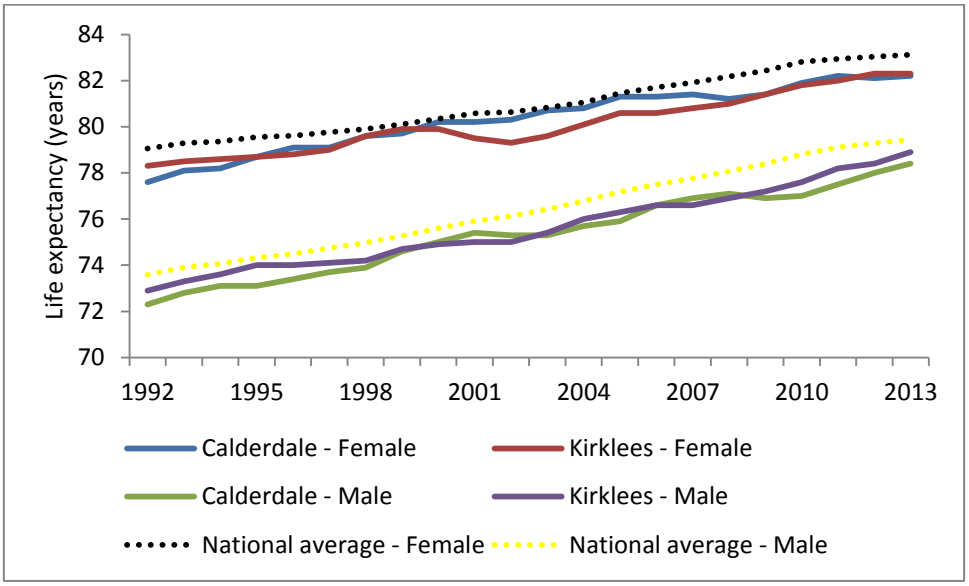


Figure 6: Life expectancy in Kirklees and Calderdale, 1992 to 2013. Office of National Statistics, Life Expectancy at Birth and at Age 65, by Local Areas in England and Wales, 1991–93 to 2012–14

- **Levels of deprivation:** There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy eating and levels of exercise and higher disease burden. The infant mortality rate for Calderdale is significantly higher than England average (7.7 per 1,000 live births compared to 4.6 per 1,000 live births)[10].
- **Health profiles:** The JSNA for the Greater Huddersfield area identified frailty, emotional welfare, obesity and cardio-vascular disease (CVD) as cause for specific concern locally. Priority areas for Calderdale in their JSNA include the management of long term conditions such as diabetes, asthma and epilepsy, mental health and the abuse of alcohol.

[10] Director of Public Health Annual Health Report for Calderdale 2012

- **Lifestyle factors:** Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is arising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors. In the Greater Huddersfield area, 52% of adults are overweight or obese and 20% of children are overweight or obese.
- **Other local service providers:** The Trust is situated between two large West Yorkshire providers of hospital services (Mid-Yorkshire Hospitals NHS Trust and Bradford Teaching Hospitals NHS Trust). The Trust's nearest Tertiary provider is Leeds Teaching Hospitals NHS Trust, which is approximately 20 miles away. The surrounding areas also include providers such as Sheffield Teaching Hospitals NHS Foundation Trust and a number of large hospital Trusts in the Greater Manchester area.

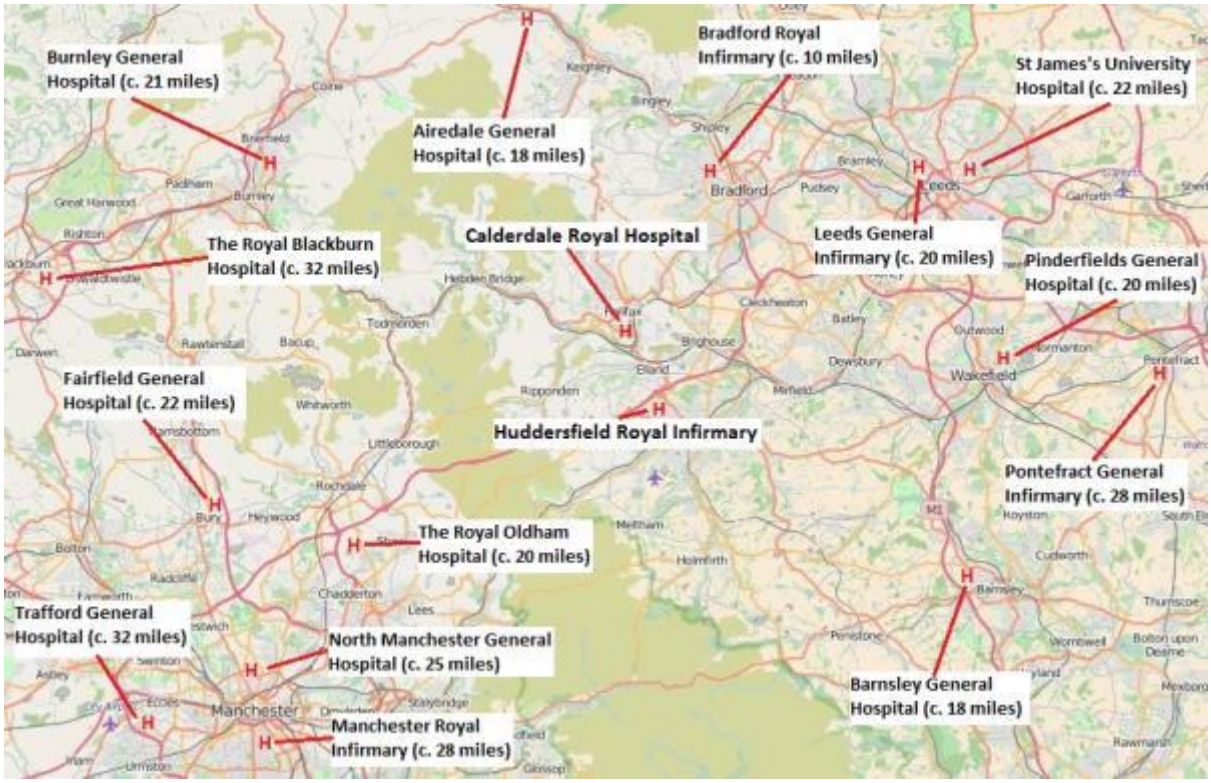


Figure 7: Local health economy

As the population increases and ages there will be significantly more operational pressure over the coming years on the Trust. Increased self-care in the community will be fundamental to reducing unplanned hospital admissions.

- **The Commissioning groups:** Clinical Commissioning Groups (CCGs) commission services for all of the people within their designated geographical area. The CCGs relevant to the Trust are Calderdale CCG and Greater Huddersfield CCG. CCGs have the ability to commission services from NHS and / or non NHS organisations. Currently the Calderdale CCG commissions the following services, amongst others:
  - CHFT Acute
  - CHFT Community
  - SWYPFT - Mental Health
  - SWYPFT - Community

  Whilst the Greater Huddersfield CCG commissions, amongst other services, the following:
  - CHFT Acute
  - SWYPFT - Mental Health
  - Locala - Community; and
  - A small proportion of activity goes to Mid Yorks

- **The Commissioners intentions:** The table below highlights commissioning priorities that are identified in the Calderdale Clinical Commissioning Prospectus and the Greater Huddersfield Clinical Commissioning Prospectus;

Calderdale Clinical Commissioning Group Commissioning Intentions and Priorities	
1	Reduced reliance on unplanned hospital based care. Maximise integrated, community based planned care.
2	Deliver best in class urgent, critical, specialist, community and primary care models which provide specialist knowledge and facilities to deliver 24/7, high quality care.
3	Integrate paediatric care. High quality paediatrics – integrating medical and surgical care (including assessment, and maximising community based delivery).
4	Develop community based unscheduled care Facilities. Community provision for minor injuries.
5	Integrated medical and surgical assessment. Single access point for adult medical and surgical assessment. Pathways focusing on care provided outside hospital wherever possible, and shared care.
6	Care Management and integrated care processes which deliver results which are in line with the best in the country.
7	Electronic records. Shared electronic planning, single shared assessment, care co-ordination and record keeping, maximising choose and book and advice and guidance.
8	Pathways integrated across multiple providers Integrated pathways delivering care across the care continuum – from specialist to low level support – led by a 'host' provider
9	Promote independence and resilience through effective use of assistive technology Maximise opportunities for integrated; teleconsultation, tele-health and tele-care in a range of settings
10	Significant increase in proportion of care provided at home or close to home Shift in balance of provision away from hospital based care into integrated community models with flexible inreach/outreach.
11	Focus on prevention and lifestyle changes – utilising every contact counts to maximise impact on both children and adults

Greater Huddersfield Clinical Commissioning Group Commissioning Intentions and Priorities	
1	Improving the quality of healthcare services and each individual's experience of care.
2	Ensuring our providers deliver high quality services.
3	Ensuring our patients get timely & appropriate access to services Increasing service integration across health & health & social care; primary & secondary care.
4	Addressing the increasing demands on health and social care (demographics and expectations).
5	Supporting people to manage their conditions and live independently
6	Making sure that the right care is delivered at the right place at the right time when people need professional help.
7	Make sure people can access high quality, safe, specialist care when needed
8	Building sustainable health and social care systems by making the best use of limited resources.

2.2.3 CHFT Trust Overview

The Trust was formed in 2001, combining hospitals in Halifax and Huddersfield to deliver healthcare for the populations of Calderdale and Huddersfield. Since then the Trust has expanded beyond hospital based services and also provides a range of community services in Calderdale. The Trust gained Foundation Trust status in 2006, which allowed the Trust to tailor its services and develop as the local health economy evolved. Further, this status enabled the Trust to develop Acre Mills in Lindley, Huddersfield with development partners Henry Boot. Acre Mills opened as a new outpatients centre in February 2015.

The Trust is divided into four clinical divisions – Surgery & Anaesthetics, Medicine, Families & Specialist Services and Community Services. These are supported by a number of corporate functions such as finance, quality assurance, human resources, estates and health informatics. Community, the newest clinical division, was launched on 1 May 2015 to reflect the increased requirement for care closer to home.

The Trust employs c.6,000 staff and delivers community services in Calderdale and hospital secondary care services at Calderdale Royal Hospital and Huddersfield Royal Infirmary, both of which have c. 400 beds. CHFT reported in 2014 /15 that they delivered 172,000 in-patient and day-case admissions, 438,000 out-patient appointments, 224,000 adult community service contacts, 64,000 children's' community service contacts and 142,000 attendances at its Accident and Emergency departments in Halifax and Huddersfield. The annual expenditure for FY15 was £343m. The range of services provided at the two acute sites include:

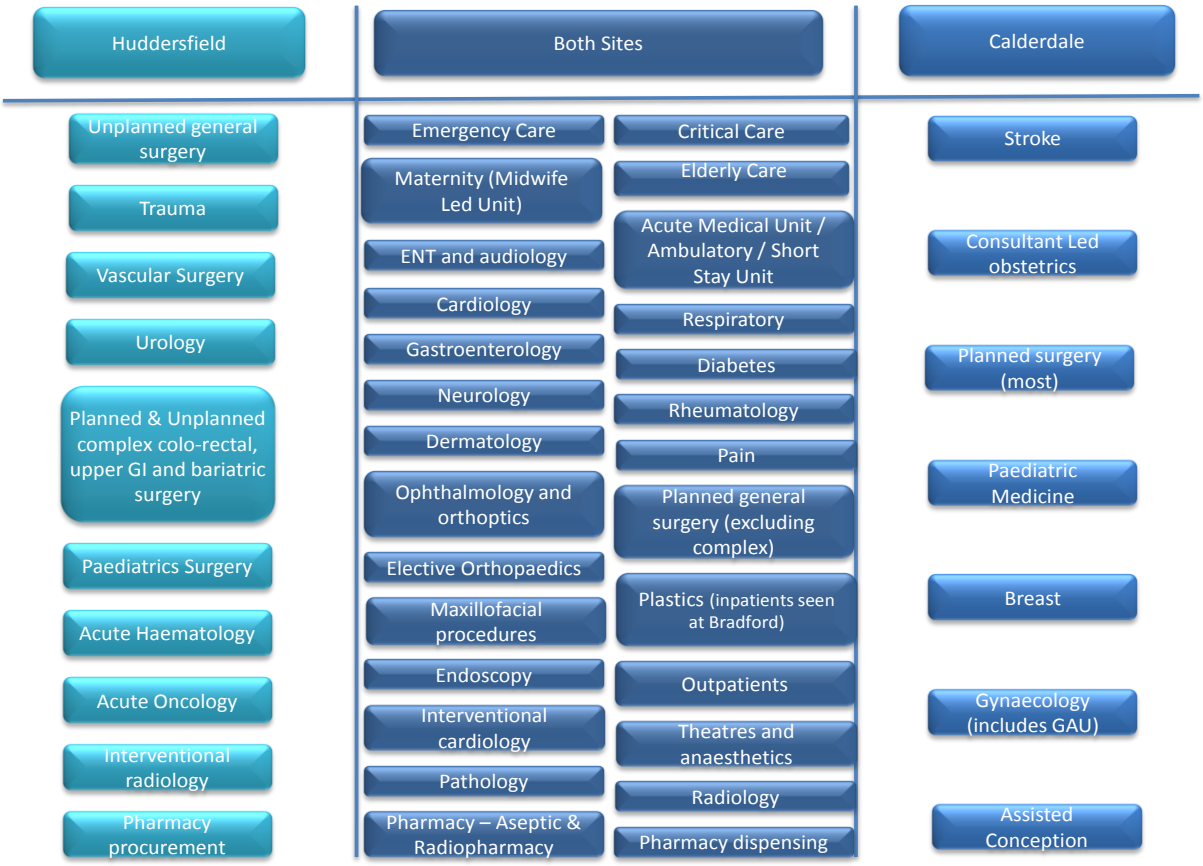


Figure 8: Acute services currently provided at CHFT

2.2.3.1 Clinical challenges facing the Trust

The Trust is experiencing a number of challenges that are affecting its ability to provide consistent, safe and high quality care. These challenges can be divided into five main categories;

- **Dual service provision**: The Trust operates across two hospital sites with some services being split across both locations. The dual site provision provides a disjointed experience to patients but also a challenging environment for staff to operate in.
- **Meeting Royal College recommendations / standards and national staffing guidance**: Both hospital sites operate an Emergency Department and a Critical Care Unit. The care provided in both of these areas is either non-compliant with some of the standards for Children and Young People in Emergency Care settings or not fully compliant with D16 guidance on critical care workforce standards.
- **Patient safety:** The Trust reports an above average higher hospital standardised mortality ratio (HSMR).
- **Inter-hospital transfers:** While some services are split across the two sites, other services are provided entirely on one single site. Therefore there are instances where patients will be required to transfer between sites according to the speciality care they require.
- **Patient experience:** The Trust reports a higher than average number of complaints per 1000 inpatient episodes. Most complaints received are in respect of Medical and Surgical & Anaesthetic Services divisions[11]. In addition, the Parliamentary and Health Service Ombudsmen (PHSO) reported that in 2014-15 on average, they received 2.9 enquiries per 10,000 clinical incidents, however, for the Trust they received 3.2 enquires.[12]
- **Care in the community:** The current service offering does not fully address care in the community in line with the Clinical Consensus Model nor is it in line with CCG community plans.

The following are key examples of how the above challenges impact the Trust's patients;

- The mortality rate is higher than the England average;
- The length of stay in hospital is longer than clinically necessary;
- Patients are being admitted to hospital with a long term condition;
- Patients are being readmitted within 30 days;
- Patients wait over 5 weeks for diagnostic services;
- Patients leave the ED without being seen;
- Patients report that they do not have a good experience when they attend an ED; and
- Patients do not have a good experience in some specialties.

The Trust is already undertaking significant performance improvement actions to mitigate against the above. These include:

- working with partners to improve integration between community healthcare and social care to ensure that people can receive the support they need at home where appropriate

[11] Board Minutes – 26 November 2015
[12] PHSO : Complaints about acute trusts 2014-15

- ensuring that every patient has a clear plan from their day of admission to their day of discharge
- putting into place a dedicated discharge coordinator for each ward to facilitate the discharge process
- implementation of ambulatory care services to ensure people can be managed appropriately in the EDs

With the pressures of increasing populations and demographics, these issues will only worsen if a move to the Clinical Consensus Model is not initiated. Whilst reconfiguration will not eliminate all of the above challenges, it will enable improvements in all of these areas to be realised.

2.2.3.2 Operational challenges facing the Trust

Workforce

The Trust, along with other NHS Trusts, is struggling to fill vacancies in the workforce due to a national shortage of skilled people. Services are expected to be put under increased pressures in the future due to forecast population growth and aging populations. . The current issues facing the Trust are listed below;

- **Provision of emergency doctors:** the Trust's current consultant pool is too far stretched to cover vacancies which the Trust has been unable to recruit for. The pressures to find the correctly skilled staff are worsened by the fact that there is currently a national shortage. In the last 5 years the Trust has only been able to provide a rota of 7 doctors, with locums filling in the gaps, the two EDs require a rota of 12 speciality doctors.
- **Flexibility of deploying staff across two sites:** Services that are split across the two locations make it difficult for vacancies or absences to be filled at short notice. In particular, the dual running of emergency medical services leads to thinly spread middle grade cover, particularly out of hours and at night.
- **Increased sickness / absence:** The Trust has a below 4% target on sickness and in the period between FY15 Q3 to FY16 Q2, each quarter has reported sickness being above this figure[7].
- **Recruitment and retention pressures:** A number of divisions are struggling to recruit and retain a substantive workforce, this impacts quality of care and patient experience. The lack of workforce also impacts the ability to implement speciality-specific rotas and delivers an on call rota of 1:5 which impacts current staff experience and hinders further recruitment. The recruitment difficulties in Surgery & Anaesthetics (N.B. not related to dual site working) have more recently led to a shortfall in elective and day case activity due to difficulty securing NHS locums.
- **High levels of locum staff:** Due to vacancies and high sickness absence amongst the workforce, a high level of locum staff is used to fill gaps in the workforce. This is expensive, provides a dis-jointed service to patients and is not sustainable in the future.

Information Technology (IT)

Currently, the Trust operates its own hardware and software for collecting and holding patient data. This is separate to the systems used by other local provider organisations in Calderdale and Greater Huddersfield. The current configuration and segregation of these IT systems does not allow for joined up and safe care.

Estates

As mentioned at the beginning of this report, the Trust operates over two hospital sites situated in Huddersfield and Halifax. Currently the configuration of services over the two sites is not sustainable due to national workforce shortages, affordability of running two sites, and the overall maintenance of two EDs at separate locations.

Originally constructed in 1965, HRI is in poor condition and time expired with significant backlog maintenance and replacement required. A survey conducted by NIFES Consulting Group in 2013 identified statutory items across the site that required immediate remedial action and recorded that the site impacted operational performance. Since the survey, the Trust has struggled to address these issues due to financial pressures. More recently, it has been estimated that £92.4m would be required to bring the estate to a category B level.

Some of the issues affecting the viability of HRI are;

- Corroded service pipework that could potentially fail;
- Leaks in the roof;
- Electricity supplies are not robust;
- Fire safety precautions are not sufficient;
- The majority of windows require replacing;
- There is asbestos within the hospital infrastructure
- Poor clinical environments

Following the agreement of the Clinical Consensus Model in October 2015, the current configuration of services is not in line with the future model proposed and would require significant work to the estate to deliver the new model of care.

The current configuration is also expensive, with backlog maintenance and upgrade required for time expired buildings at the HRI site amounting to £92m and the PFI at the CRH site amounting to an annual revenue cost in excess of £20m (including hard and soft facilities management). These costs are not sustainable.

2.2.3.3 Financial challenges facing the Trust

Historic trading

CHFT has recently enjoyed a period of delivering surpluses. In FY11, the Trust delivered a £1.8m surplus, rising to £3.7m in FY12. In FY13 the Trust reported a deficit of £2.3m, driven by a £6.3m impairment. Excluding this accounting adjustment, the Trust's surplus would have been £4.0m. The following year, in FY14, the Trust reported a £0.6m surplus.

For FY15, CHFT submitted a plan to Monitor that delivered a £3.0m surplus for the year and £4.7m surplus in FY16. However the Trust revised its FY15 forecast outturn in M6 to a £4.3m deficit. The Trust was underperforming against its contract to the value of £6.5m but benefitted from £4.9m of contract protection under its fixed-value contract with its two main commissioners. CIP delivery was also significantly behind plan by £9.7m. The Trust's outturn for the year was a £6.3m deficit, a further £2.0m behind its revised forecast.

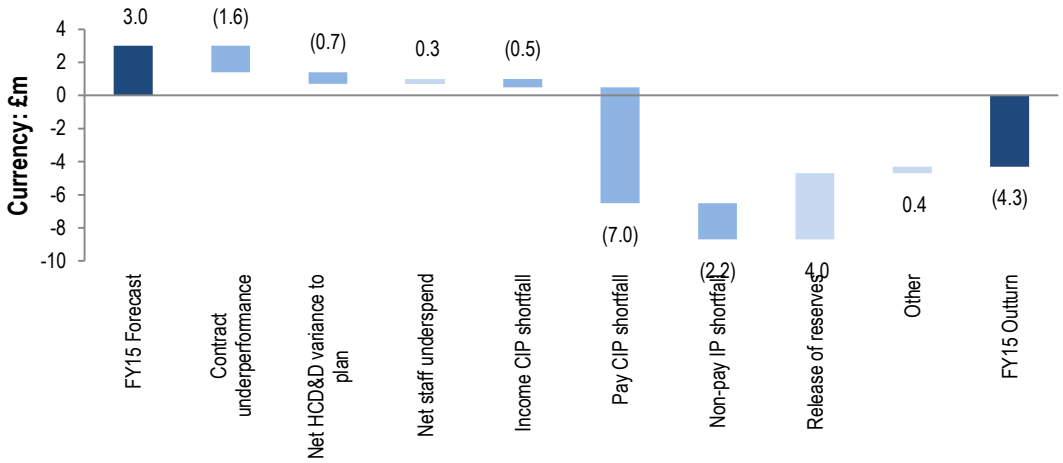


Figure 9: Bridge - FY15 forecast to FY15 revised forecast

FY16 financial challenge

The Trust's FY16 plan submitted to Monitor showed a deficit position of £20.0m (plus £1.0m of restructuring costs that were allowed to be classed as exceptional and reported below the line). CHFT faced a £5.9m reduction in its income quantum arising from its contract underperformance delivered in FY15 and the subsequent move to a tariff-based contract. Pay costs pressures of £5.4m included £1.7m of safer staffing requirements. Non-pay cost pressures amounted to £5.7m, incorporating £2.2m of full-year revenue effects of capital programmes.

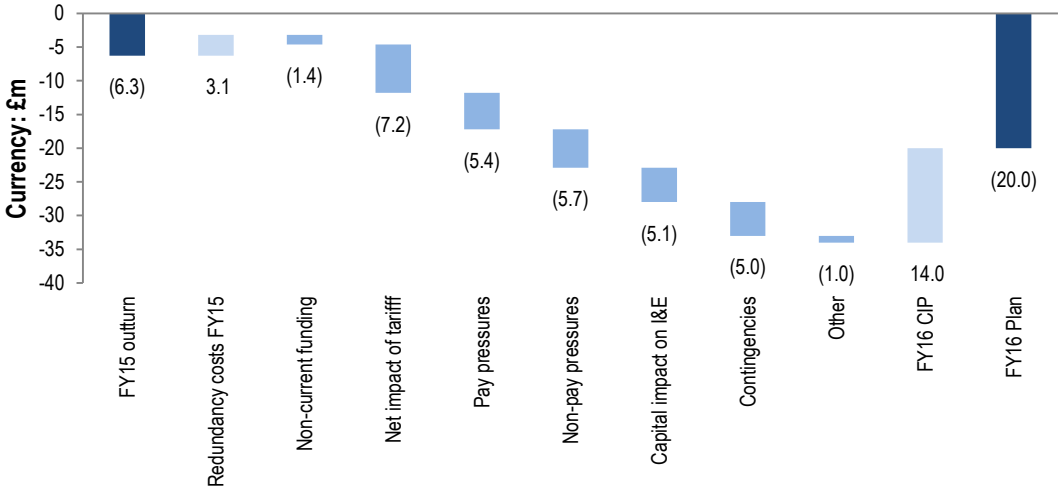


Figure 10: Bridge - FY15 Outturn to FY16 Plan

Up to M6, the Trust has underperformed on its elective and day case income contract to the amount of £2.6m. This is a key driver of its FOT position being £2.0m below its plan. However, it should be noted that a key driver for this is an increased number of non-elective admissions as a result of reduced out of hospital nursing home capacity, which is applying both cost and operational pressures. As the year has progressed, the Trust has revised its FOT to deliver a deficit of circa

£20.0m, broadly in line with Plan. This is due to an upturn in performance in elective and day case activity whilst non-elective activity continues to over perform against Plan.

FY17 financial challenges

The Trust has brought forward its annual planning process to coincide with the development of this strategy. The baseline position, before taking into account the impact of any strategic initiatives or reconfiguration of services, see the Trust's deficit increase to £33.0m. This provides the basis on which the remainder of this 5 Year Strategy is built.

3. Structure of Approach

A set of 15 priority strategic initiatives have been identified to support the Trust over the next 5 years. A key component of these is hospital reconfiguration, with Calderdale Royal Hospital as the preferred option for an unplanned care site, and Huddersfield Royal Infirmary or Acre Mills as the preferred option for a planned care site.

- **The overall development of the plan has been framed by a set of strategic questions** developed by the Board.
- **An agreed list of appraisal criteria has been developed by the Trust Board, against which the options facing the Trust have been appraised.** This is in alignment with the Monitor Toolkit, and Treasury Green Book guidance.
- **These have been used by the Board to develop a shortlist of**:
  - 15 priority initiatives to be taken forward over the 5 year time horizon of the plan.
  - 3 estate reconfiguration options to support implementation of a proposed new model of care.
- **Further development, including indicative benefits and costs associated with the 15 priority initiatives have been developed to underpin the 5 year strategic plan.**
- **Application of the agreed criteria, together with a set of supporting critical success factors, has been used to determine the preferred estate reconfiguration.**
- **This plan is closely linked with proposed local health economy changes and does take into account proposed changes at Dewsbury Hospital.** However, it does not include any quantified impact from wider West Yorkshire changes, such as collaborative working and social care changes.
- **In development of its 5 year strategic plan, on assumption has been made on changes in the provider of choice for community services going forwards.**
- **At key points in the development of this 5 year plan, the Membership Council has been engaged to provide a check and challenge on the process.**
- **A key component of the strategic initiatives contained within this plan is the undertaking of more strategic alliances and closer working with other providers, including acute providers, providing the Trust with flexibility to address future challenges.**
- **The preferred estate configuration has changed since development of the Outline Business Case (OBC). Within the OBC, Huddersfield was stated as the preferred option for the unplanned care site; this has now shifted to Calderdale Royal Hospital as the preferred location for the unplanned care site.**
  - This change is primarily for financial reasons, as there is very little differential between Huddersfield or Calderdale as the unplanned care site on other grounds.

- Use of CRH as the unplanned care site is associated with a £3.3m (nominal) annual running cost saving (in real terms) compared with HRI being the unplanned care site. These benefits are anticipated to be further enhanced by savings in capital costs and PDC dividend payments.
- In the absence of a credible means of exiting the PFI at Calderdale, and given the financial position of the Trust, CHFT cannot support and further develop a time expired building at Huddersfield.

3.1 Strategic questions the plan will address

Using the Monitor toolkit[13] as a basis, the Board discussed the questions that the 5 Year Strategic Plan should answer at a workshop on the 14th October 2015; these were divided into clinical, operational and financial questions. Each question was considered in the context of the desired outcome of the Plan and the possible impact that each question will have on the Trust's stakeholders. The Board agreed on the following 12 strategic questions that the Plan should address;

Clinically focused
How will the Trust meet all quality and safety requirements – both clinical and non-clinical?
How will the Trust redesign services across all sites for the local community to ensure the Trust is clinically and operationally viable?
How can the Trust strengthen professional relationships, engaging with the wider health and social care economy and the local system to maximise opportunities for collaboration to meet the population's health and social care needs?

Operationally focused
How will the Trust support Commissioners to commence public consultation on the future configuration of services across all of the sites in January 2016?
What should the Trust do to develop a workforce plan with a specific focus on securing the right skills and capacity to deliver the plan, including improved workforce recruitment and retention?
How can the Trust improve staff engagement and satisfaction across the Trust?
How will the implementation of EPR and technology enable new ways of working which support delivery of the 5 year strategy?
What should the Trust do to engage staff to ensure successful delivery of the plan?
What impact will the plan have on the Trust's stakeholders?

[13] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Financially focused
How will the Trust return to a sustainable surplus and secure necessary enabling and interim national funding support, within the context of the current and future fiscal environment?
Should the Trust continue with its existing portfolio of acute and community services, or have a more narrow focus, with some services being delivered exclusively by, or in partnership with, other local providers?
What can the Trust do to make best possible use of the total Trust estate in particular the PFI site, including possible divestment options?

These strategic questions have been used to frame the overall objectives of the plan, and guide the development of the plan.

3.2 Appraisal criteria

Having agreed the over-arching framework for the 5 Year Strategic Plan in terms of the strategic questions that should be addressed, a set of criteria were developed to provide a basis for prioritisation and appraisal of the options facing the Trust. In particular, for prioritisation of a long list of potential initiatives that the Trust could take forward, as well as for appraisal of the specific estate options being considered by the Trust.

At the workshop on the 14th October 2015, the Board considered the criteria used in the Trust's previous OBC, together with Monitor's suggested criteria provided in the Monitor toolkit. After considering both sets of criteria, the Board agreed upon five assessment criteria which are below, underpinned by a number of specific critical success factors:

Criterion	Critical success factor description
Quality of Care	► Deliver improvements to our clinical quality and safety whilst giving best chance of achieving our hospital standards ► Provides a better experience for patients ► Provides a better experience for staff ► Enables supportive self-management
Access to Care	► Quality and equality impact assessment for both adults and children. This covers 4 areas: 1. Improved patient ability to access the right treatment in the most appropriate setting. 2. Minimising the average and/or total time it takes people to get to hospital by ambulance, public transport and car (off-peak and peak) 3. Car parking facilities 4. Minimise delays in care pathways, once in receipt of care
Value for Money	► Most likely to return the Trust to sustainable financial position within the context of a balanced Health and Social Care System ► Provides the most positive net present value (NPV) over 30 years, return on capital and other financial requirements ► Delivers improvement of headline profitability ratios (e.g. Carter) ► Improves income / cost balance of individual service lines ► Minimises the need for capital through a diversity of funding sources

Deliverability & Sustainability	► Minimises avoidable harm during transition ► Provides the most cost effective reconfiguration of services ► Minimises the time taken to deliver the proposed changes ► Delivers robustness over a 20 year time horizon ► Supports attraction and retention of staff
Co-dependencies with other strategies	► Demonstrates sufficient flexibility to integrate/improve partnership working with, for example, the Local Authority/ Social Care/ GPs and Third Sector. ► Alignment with Joint Strategic Needs Assessment (JSNA) ► Maximise resilience to wider system / organisational failure

3.3 Shortlisting of initiatives and estate options

As described in the sections above, the 5 Year Strategic Plan builds upon the items developed in the SOC and OBC. As part of these developments, the Trust devised a long list of forty initiatives that the Trust could implement to improve future sustainability. The long list of initiatives can be found in Appendix 10.4 of this report.

At a full Board workshop in early October 2015, the Board discussed the forty initiatives at length and scored each one against the appraisal criteria. Each initiative was given a score between 1 and 5 for each of the criteria to determine whether the initiative was aligned to the overall framework of the Plan.

The Board agreed upon 15 priority initiatives to be taken forward for quantification. These are listed below;

1. Reconfiguration of hospital services
2. Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
3. Address clinical variation ensuring delivery of consistent standardised evidence based care
4. Optimise 7-day working within resources
5. Optimise community service model to reduce demand on hospital incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics
6. Workforce and skills planning
    i. Trust skill mix and workforce plan
    ii. Integrated multi-disciplinary approaches to care
    iii. Volunteers and 3rd sector
7. Reduce Bank & Agency use and deliver sustainable sickness absence reduction
8. Enhancing productivity of community work
9. Optimise information technology benefits
10. Reduce hospital and community demand by increasing prevention and self-care support for the population
11. MCP Vanguard - New Care Models that offer integrated community, primary and acute care

12. Develop / invest in strategic partnerships (e.g. GP Federation, voluntary sector, other organisations)
13. Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University
14. Introduce innovative finance structures that enable savings
15. Identification of service development opportunities to ensure we maximise income for the Trust.

Full details of the initiatives and initiative leaders can be found in Section 4.

Similarly, the Trust developed a list of seven estate options that were available to the Trust. These options included the use of the current estates owned by the Trust, but also considered estate options that would require the use of additional or alternative estates. Any estate options that did not meet the requirements of the Clinical Model were not taken forward for detailed analysis. This left three main estate options as identified below for consideration. The full list of the seven estate options can be found in the Commercial case section of this report.

The agreed list of estate options to take forward for quantification in the 5 Year Strategic Plan can be found overleaf;

	Reconfiguration Option	Rationale for taking forward
1	**Base case** Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfiguration).	► Needs to be taken forward as the base case for comparison in accordance with Treasury Green Book guidelines
4	**Emergency and Acute Care Centre and high risk planned care delivered at CRH.** CRH provides all acute and emergency care and clinically high risk planned care. Elective services and an Urgent Care Centre are provided at HRI (main site and / or Acre Mills)*	► Responds to the National Clinical Advisory Team's recommendations ► Could offer a clinically and financially sustainable model ► Recommended options to be taken forward for further appraisal in the Outline Business Case
5	**Emergency and Acute Care Centre and high risk planned care delivered at HRI (main site and / or Acre Mills).** HRI provides all acute and emergency care and clinically high risk planned care. Elective services and an Urgent Care Centre are provided at CRH*	

*Both options 4 and 5 include the provision of Urgent Care services at the acute site. The model also includes a potential third site as agreed in the Clinical Model.

3.4 Analysis undertaken and the preferred option

The priority initiatives were discussed with each of the Trust's divisions to understand the impacts that are expected to be generated over the 5 year period. In addition to identifying savings, divisions were also asked to provide an indication of any cost pressures that may arise as a result of the priority initiatives.

The shortlist of estate options were taken forward for further analysis against the agreed criteria, and in particular for;

- Clinical benefits;
- Patient pathways;
- Patient travel times;

- Capital requirements;
- Bed capacity;
- Wider health economy forecasts;
- Commissioner intentions; and
- QIPP.

Each of the shortlisted estate reconfiguration options has been assessed against the appraisal criteria to determine a preferred option for the 5 Year Strategic Plan.

Each criterion was associated with a critical success factor as shown in the tables below. The findings from the above analysis and the quantification of the options were jointly appraised against the critical success factors at a Board meeting on the 9th December 2015 to determine which option would be the preferred option to take forward. At key points in the development of this 5 year plan, the Membership Council has been engaged to provide a check and challenge on the process.

Quality of Care			
Critical success factors	Evaluation of options		
The proposed model of care will: - **Support CHFT in meeting clinical standards**, irrespective of the choice of planned care site - Support redesigned care pathways to enhance quality - Improve the Trust's ability to provide emergency and other clinical cover - Support cuts in avoidable admissions	Base case	- Difficult to meet clinical standards in current service configuration - Current pathways do not deliver quality care - Dual service provision is hard to resource - Community services not well established	X
	CRH unplanned	- In line with NCAT recommendations for improved care - In line with Clinical Consensus Model - Reconfiguration allows for better deployment of workforce - Community work has a better platform from which to operate	✓
	HRI unplanned	- In line with NCAT recommendations for improved care - In line with Clinical Consensus Model - Reconfiguration allows for better deployment of workforce - Community work has a better platform from which to operate	✓

<table>
<tr><th colspan="4">Access to Care</th></tr>
<tr><th>Critical success factors</th><th colspan="3">Evaluation of options</th></tr>
<tr><td rowspan="3">The proposed model of care will:

► Improve patient ability to access the right treatment in the right setting

► There are no protected groups who are likely to be highly impacted by the proposed changes

► There is no material difference in average travel time impact between the two unplanned care site options

► Car parking in accordance with benchmark norms has been included in the capital estimates

► The proposed model of care is anticipated to improve patient productive time through co-location</td><td>Base case</td><td>► Currently patients are not seen in the right setting and ED visits are high
► There will be no change in patients' travel time or car parking
► Services are not co-located and therefore patient productive time is not improved</td><td>X</td></tr>
<tr><td>CRH unplanned</td><td>► Reconfiguration does not negatively affect the population relative to deprivation, age and race
► Blue light ambulance travel time is within 45 minutes, within the parameters for clinical safety
► Public transport travel times are longer, however, not disproportionately so when considering the total population
► Car parking facilities are increased
► Patient productive time is increased as a result of co-location of services</td><td>✓</td></tr>
<tr><td>HRI unplanned</td><td>► Reconfiguration does not negatively affect the population relative to deprivation, age and race
► Blue light ambulance travel time is within 45 minutes, within the parameters for clinical safety
► Public transport travel times are longer, however, not disproportionately so when considering the total population
► Car parking facilities are increased
► Patient productive time is increased as a result of co-location of services</td><td>✓</td></tr>
</table>

Value for Money			
Critical success factors	Evaluation of options		
The proposed model of care will: ► Yield a positive movement in forecast income and expenditure relative to the base case ► Forecast the most positive recurrent revenue and cash flow position from the investment (reflecting the return on capital invested) ► Improve Trust EBITDA (Earnings before interest, tax, depreciation and amortisation) position. ► Increases in income and / or decreases in cost for individual service lines ► Number of proposed funding sources	Base case	► The base case does not provide for an improved income and expenditure position ► There is no initial investment to drive a positive move in cash flow ► Trust EBITDA is not improved ► Potential to increase income and cost savings from implementation of initiatives ► Will require local funding	X
	CRH unplanned	► Subject to any potential PFI impact, provides the most positive movement in income and expenditure[14] ► Provides the most positive recurrent revenue and cash flow position ► Delivers the greatest improvements to net margin ► Potential to increase income and cost savings from implementation of initiatives ► Mixture of local and central funding	✓
	HRI unplanned	► Provides a small (£0.8m) positive movement in income and expenditure ► Delivers an improvements to net margin ► Potential to increase income and cost savings from implementation of initiatives ► Mixture of local and central funding	X

[14] Note: The above analysis does not include any potential incremental costs or limitation associated with the CRH PFI. These will need to be the subject of negotiation with the CRH PFI provider.

<table>
<tr><th colspan="4">Deliverability and Sustainability</th></tr>
<tr><th>Critical success factors</th><th colspan="3">Evaluation of options</th></tr>
<tr><td rowspan="3">The proposed model of care will:

► Minimise avoidable harm during transition

► Provide a cost effective reconfiguration of services

► Realise benefits within a 5 year time horizon

► Support sustainability over the medium term

► Support improvements in staffing resilience and flexibility</td><td>Base case</td><td>► No transition
► Services are not currently cost effective
► Benefits of the initiatives will be realised within 5 years
► The current configuration of services is not sustainable
► Dual provision of services on separate sites does not allow staffing resilience or flexibility</td><td>X</td></tr>
<tr><td>CRH unplanned</td><td>► Will require a plan to maintain services during transition
► Same one-off reconfiguration cost as HRI unplanned option
► Benefits of the initiatives will be realised within 5 years
► Supports future sustainability (significant improvement on do nothing or base case)
► Supports improvements in staffing resilience and flexibility</td><td>✓</td></tr>
<tr><td>HRI unplanned</td><td>► Will require a plan to maintain services during transition
► Same one-off reconfiguration cost as CRH unplanned option
► Benefits of the initiatives will be realised within 5 years
► Supports future sustainability (significant improvement on do nothing or base case)
► Supports improvements in staffing resilience and flexibility</td><td>✓</td></tr>
</table>

Co-dependencies with other strategies			
Critical success factors	Evaluation of options		
The proposed model of care will: ► Be aligned with LHE plans ► Be aligned with JSNA and Joint Health and Wellbeing Strategy (JHWS) ► Change forecast bed occupancy	Base case	► Current configuration is not sustainable considering future LHE plans ► No alignment with JSNA or JHWS ► No resilience to bed occupancy	X
	CRH unplanned	► Directly aligned with LHE ► Supports delivery of JSNA and JHWS priorities ► Improves resilience through a reduction in forecast bed occupancy, improving recruitment and retention of workforce	✓
	HRI unplanned	► Directly aligned with LHE ► Supports delivery of JSNA and JHWS priorities ► Improves resilience through a reduction in forecast bed occupancy, improving recruitment and retention of workforce	✓

Based on the analysis undertaken and summarised in the tables above:

- There is an overwhelming benefit to moving to the proposed model of care across the two main current sites.
- The choice between HRI and CRH as the unplanned care site is primarily financial.
- CRH as the unplanned care site is forecast to provide the most positive financial position, subject to successful renegotiation with the CRH PFI provider.

The preferred option is therefore for Calderdale Royal Hospital to be the unplanned care site, with Huddersfield Royal Infirmary (some, or all, of the main site or Acre Mills) as the planned care site.

This preferred option for the site of the planned and unplanned care site represents a change since development of the Strategic Outline Case. Within the SOC, Huddersfield was stated as the preferred option for the unplanned care site; this has now shifted to Calderdale Royal Hospital as the preferred location for the unplanned care site.

- This change is primarily for financial reasons, as there is very little differential between Huddersfield or Calderdale as the unplanned care site on other grounds.
- There is now a much stronger understanding of and joint commissioner and provider agreement on the clinical model. Analysis of activity drift (within the Clinical Case section of the 5 year plan) indicates no material difference between either of the two sites as the unplanned care site.
- Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include;
    - Exploration of use of retained estate from the current CHFT build;

- Use of Dryclough Close (estate on the CRH site owned outright by CHFT);
- Increasing the number of vertical stories on the new build;
- Multi-story car park development; and
- Development on adjoining land.

These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere.

- Access to CRH from the motorway and Huddersfield is also set to improve by 2021, with a significant investment in Halifax to Huddersfield A629 Corridor Improvements planned as part of a £1.4bn programme of transport improvements for West Yorkshire and York.
- Crucially, use of CRH as the unplanned care site is associated with a £3.3m annual running (nominal) cost saving compared with HRI being the unplanned care site. These benefits are anticipated to be further enhanced by savings in capital costs and PDC dividend payments. This protects resources for other healthcare needs.
- CRH as the unplanned care site may enhance the Trust's ability to secure capital finance if DH cannot afford the sum required.
- The Trust has the option to gain sale proceeds from HRI to further reduce the ongoing debt in the health economy.
- Whilst there are risks associated with undertaking development on a PFI site, these are untested, and in the absence of a credible means of exiting the PFI at Calderdale, and given the financial position of the Trust, CHFT cannot support and further develop a time expired building on the Huddersfield main site.

Further detail on the preferred site rationale and comparisons with that used in the SOC and OBC are available in the appendix (section 10.7).

4. Short list of 5 Year Strategic Plan Initiatives

A short list of priority initiatives to support the Trust over the next 5 years has been identified. These are split into strategic and operational opportunities, and will be taken forward by agreed accountable and responsible leads within the Trust

- **Strategic initiatives**
  - Reconfiguration of hospital services
  - Optimise 7-day working within resources
  - Optimise community service model to reduce demand on hospital incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics
  - Optimise information technology benefits
  - Reduce hospital and community demand by increasing prevention and self-care support for the population
  - MCP Vanguard - New Care Models that offer integrated community, primary and acute care
  - Develop / invest in strategic partnerships (e.g. GP Federation, voluntary sector, other organisations)
  - Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University
  - Introduce innovative finance structures that enable savings

- **Operational Initiatives**
  - Identification of service development opportunities to ensure we maximise income for the Trust
  - Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
  - Address clinical variation ensuring delivery of consistent standardised evidence based care
  - Workforce and skills planning
  - Reduce Bank & Agency use and deliver sustainable sickness absence reduction
  - Enhancing productivity of community work

4.1 Strategic Initiatives

The Trust has developed a range of strategic initiatives that are aimed at generating savings, improving productivity and efficiency, generating income and developing partnerships to improve quality of services offered to patients. The following section provides a high level summary of each of these initiatives, including the initiative owners and key steps for delivery. This section only summarises the initiatives and underpinning activities as of December 2015. As the initiatives develop there will be scope for further benefits to be identified and realised.

Note: 'Reconfiguration of hospital services' was decided upon by the Board as one of the 15 initiatives to take forward for quantification. However, as the crux of the Five Year Strategic Plan is an overall, Trust-wide reconfiguration of services, a separate summary has not been included here.

4.1.1 Optimise 7-day working within resources

Summary

Embrace 7-day working at the Trust in line with the 10 National Clinical Standards.

Trust accountable lead: David Birkenhead **Trust responsible lead**: Sal Uka

A Objective 1: Determine the Trust's strategy towards the 10 National Clinical Standards.

B Objective 2: Progress with the implementation of the five prioritised from the 10 National Clinical Standards. These standards have been identified as having the greatest impact locally by FY16 (2, 4, 5, 6, 8).

C Objective 3: Aspire to delivery of all ten clinical standards by 2017/2018.

D Objective 4: To ensure ongoing monitoring of performance and compliance in relation to the standards.

Activities

A Establish a comprehensive view of the costs and benefits, workforce and infrastructure requirements to inform the Trust's decision making process and strategy.
A Explore alternative ways of working to achieve 7-day working within current resources.
A Understand Commissioner intentions and expectations both locally and nationally.
B Explore network agreements for any services not provided at CHFT over 7 days.
C Determine a roadmap and financial analysis to meet all 10 standards by 2017/2018.

Benefits and cost

Financial

- A £1m cost pressure has been included in the 16/17 plan. Anything over and above this will need to be cost neutral i.e. where divisions are able to make savings that pay for the cost of implementation.

Non-financial

- Compliance with the 10 national standards will improve the quality of care and reduce LOS, readmission rates and mortality rates.
- Possible flexible working for staff.

Incremental capital outlay: None **Incremental revenue cost**: None

Challenges

- Recruitment of additional staff will be required.
- Finances involved in meeting the standards (and 7-day care in general) exceed availability.
- Lacks a whole system approach to delivery of 7-day working.

Criteria

Quality of care	Increased clinical attention and reduced LOS.
Access to care	Increased access through 7-day working.
Value for money	Possible long-term cost improvements via reducing LOS.
Deliverability and sustainability	Funding and staffing requirement may prove unsustainable.
Co-dependencies	High: Reliant on 7-day community and social care provision and clinical support services.

4.1.2 Optimise community service model to reduce demand on hospital, incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics

Summary

Increase the focus on new models of care and patient-centred care. Introduce a new approach to outpatient care. Note similar work will be required by the Kirklees community provider.

Trust accountable lead: Helen Barker	**Trust responsible lead:** Mandy Gibbons-Phelan

A	Objective 1: Improve community service care models to reduce hospital activity required.
B	Objective 2: Understand the benefits available from gain-share mechanisms.
C	Objective 3: Learn from the MCP Vanguard project to inform further rollouts of innovative ways to deliver community care (including using learnings for implementation in Huddersfield).

Activities	
A	Rollout C3 Community Children's healthcare, rapid access hot clinics and paediatric telephone advice across localities.
A	Explore expansion of QUEST care home model.
A	Explore expansion of Vanguard activities and incorporating other allied healthcare professionals to expand the range of services and expertise offered.
B	Explore the gain-share mechanism and consider reaching a mutually beneficial agreement with the Commissioners.
B	Maximise the benefits from utilising IT to support community care, e.g. EPR.

Benefits and cost

Financial	Non-financial
• Liaison with Pennine GP alliance to optimise community pay. • Income changes that will need reflecting in cost reductions.	• Improved care experience, independence and care at home benefits for patients. • Integrated community model particularly beneficial in a rural area. • Potential patient benefits from reductions in LOS and DTOC.

Incremental capital outlay: None	**Incremental revenue cost**: Within existing budget

Challenges

- Change in working practices.
- Access to shared records across primary and secondary care.
- Estate implications of service expansion.
- Establishing effective coding and counting following move away from block contract.

Criteria

Quality of care	Increased quality due to lower demand on hospital. Ensures the right patient accesses the right care in the right place.
Access to care	Better access to care and better services outside of the hospital.
Value for money	Reduced number of patients being admitted to hospital.
Deliverability and sustainability	Difficult to reach wider community. Staffing issues.
Co-dependencies	High: IT and shared records.

4.1.3 Optimise information technology benefits

Summary

Utilise IT, particularly an Electronic Patient Records (EPR) system, to improve the clinical practice, deliver savings across the Trust and generate income.

Trust accountable lead: Mandy Griffin	**Trust responsible lead**: Julia Colletta **Trust responsible lead**: David Lang

A	Objective 1: Create integrated and accessible functional systems to maximise the benefits of EPR.
B	Objective 2: Drive down variations in care by monitoring clinical performance.
C	Objective 3: Generate income from the Health Informatics Service (HIS).

Activities	
A	Formalise a plan for the EPR to 'go live' and consider the logistics of the launch, including the phasing and additional requirements during the early stages.
A	Review the Trust's digital roadmap for further efficiency and cost saving opportunities from the tactical deployments to date.
A	Quantify the benefits of the above to inform future options appraisals for other IT systems, including E-rostering and tele-health.
B	Harmonise bed management, medicine management and test ordering to the EPR system.
C	Explore the potential of generating additional income for the Trust from HIS.

Benefits and cost

Financial	Non-financial

• £4.31m, including savings of:
  ○ Litigation costs, £170k recurrent.
  ○ Costs from displaced systems, c. £390k in FY17.
  ○ Administrative costs, c. £250k.
	• Added value in identifying clinical performance trends, strengths and weaknesses.
	• Enhanced patient information access.
	• Patient monitoring, care and safety.

Incremental capital outlay: £4m pay; £5.8m non-pay (EPR only); £22.9m total	**Incremental revenue cost**: £0.33m pay; £1.04m non-pay (EPR only)

Challenges

- Management of performance during implementation.
- Unforeseen additional costs (ongoing maintenance costs have been accounted for).
- Costs of support during implementation may exceed expectations.
- Ongoing governance and sustainability of use post-implementation.
- Relationship management with Bradford NHS Foundation Trust.
- There may be a one-off loss of clinical income as a result of the EPR implementation. A non-recurrent allowance for this loss of £5m in the FY17 position has been made within the financial forecast.

Criteria

Quality of care	Likely to reduce clinical variation and raise standards.
Access to care	Indirect benefit as a result of increased patient throughput.
Value for money	Some reduction in administrative and support costs.
Deliverability and sustainability	Risk of significant disruption during implementation.
Co-dependencies	Compliance with Government and Data Protection legislation.

4.1.4 Reduce hospital and community demand by increasing prevention and self-care support for population

Summary

Proactively inform and encourage the population of Greater Huddersfield and Calderdale to make positive lifestyle changes, with an emphasis on tackling obesity and smoking.

Trust accountable lead: Helen Barker	**Trust responsible lead**: Diane Catlow

A Objective 1: Alignment with primary and community public health plans.

B Objective 2: Educate the population.

C Objective 3: Generate a gain-share cash dynamic that benefits the system.

Activities
A Assess the intentions and expectations of the Commissioners and Trust regarding self-care.
B Develop self-care plans for patients with long-term conditions and explore options for accessing hard to reach groups (e.g. rural communities, languages, etc.).
B Introduce/expand the programme for the training of patients, carers and GP practice staff. Review the use of alternative models for delivery (i.e. volunteers).
B Review the patient pathway from primary and community care to acute services, and identify improvements to augment self-care and care in the community.
C Explore the mechanics of gain-share with the Commissioners.

Benefits and cost

Financial	Non-financial
• Potential gain-share mechanism.	• Patient experience and independence. • Shared decision making. • Less demand on stretched resources at each provider. • Long term effects of healthier population.

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- Culture change from ED as first port of call.
- Difficulties with influencing hard-to-reach groups.
- Stretched public health resources.
- Block community care contract – difficult for the Trust to derive a benefit.

Criteria

Quality of care	Improvements via targeted resources.
Access to care	Wider patient understanding and independence.
Value for money	Prevents problems before costly complications occur.
Deliverability and sustainability	Resource and time intensive.
Co-dependencies	Further staffing requirement on already strained resources.

4.1.5 MCP Vanguard – New Care Models that offer integrated community, primary and acute care

Summary

The MCP Vanguard offers a community-focused new model of care (in accordance with the FYFV) that recognises the region's rural areas and tailors out-of-hospital care accordingly.

Trust accountable lead: Helen Barker	**Trust responsible lead**: Mandy Gibbons-Phelan

A	Objective 1: Enhance the current Vanguard offering with further new care models.
B	Objective 2: Utilise the resources of the CHFT Community division and Pennine GP Alliance to deliver an effective and integrated community care model.
C	Objective 3: Reduce the Trust's cost base and generate income through new care models.

Activities	
A	Implement Care Closer to Home (CCTH) programme in conjunction with other local care providers, particularly the Pennine GP Alliance.
A	Operate a Health & Social Care single point of access integrated with other services across Calderdale with the aim of providing an improved patient pathway.
A	Review the effectiveness of the Vanguard model to gauge change and replicability. Collect feedback and identify improvements.
B	Expand patient cohorts across the localities and accelerate the rollout.
C	Explore income generation via a capital based approach, payment mechanisms or the Better Care Fund.

Benefits and cost

Financial	Non-financial
• Savings included in QIPP.	• Responsive and coordinated care. • Reduce the potential years of life lost amenable to healthcare (PYLL) and improve the health related quality of life due to earlier diagnosis. • Empower people and communities.

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- Success of the programme difficult to monitor – how will the long term benefits be monitored?
- Plan requires sufficient resourcing of suitably skilled staff to ensure success.
- Funding after initial support from Vanguard.

Criteria

Quality of care	Improves the patient experience and quality of care.
Access to care	Improves access, especially pertinent in a rural area.
Value for money	Delivers cost savings and reduced pressure on hospitals.
Deliverability and sustainability	Requires sustained commitment from the partners.
Co-dependencies	Primary care resource support.

4.1.6 Develop / invest in strategic partnerships (e.g. with GP Federations, voluntary sector, other organisations)

Summary

Forge mutually beneficial partnerships to facilitate income generation, costs reductions and an enhanced service for patients and staff.

Trust accountable lead: Anna Basford	**Trust responsible lead**: Catherine Riley

A	Objective 1: Explore partnership opportunities to facilitate shared services, staff, research and procurement with the West Yorkshire Association of Acute Trusts (WYAAT).
B	Objective 2: Continue to leverage the relationship with the Pennine GP Alliance (in alignment with the MCP Vanguard – see section 4.1.5).
C	Objective 3: Reduce costs or generate income through operational partnerships.
D	Objective 4: Develop partnerships building on the planned EPR implementation.
E	Objective 5: Increase utilisation of the voluntary sector.

Activities	
A	Co-location of pharmacy stores to a single unit for the Trust or in collaboration with Bradford or Mid-Yorks initially. Joint tendering of immunology service and a shared dermatology service with Leeds or Bradford to save locum costs.
A	Develop a shared business and Clinical Model for delivery of vascular surgery services.
A	Onsite aseptic facilities and stores – possible collaboration with Bradford or Mid-Yorks.
A	Establish a shared radiology on-call provision with the WYAAT.
A	Development of a partnership for drug procurement, storage and medical information.
C	Explore the possibility of a university partnership to increase training income.
D	Explore opportunities enabled through EPR and shared access to records with primary care and other secondary care providers.
E	Explore partnerships with charity or other voluntary sector organisations.

Benefits and cost

Financial	Non-financial
• £167k for co-location of pharmacy stores with Bradford and Mid-Yorkshire Trusts. • Increased economies of scale for the procurement function. • Partnership with specialist institutions may result in additional income.	• Enhanced training and development opportunities for staff. • Knowledge sharing.

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- Governance – need to clarify who is ultimately responsible for the partnership.
- Consistency of care across the partnership.
- Risk transfer through collaboration.

Criteria

Quality of care	Increased consistency of delivery, expertise and innovation.
Access to care	Wider access to services through partnerships.
Value for money	Greater value through economies of scale.
Deliverability and sustainability	Compatibility and partnership terms & conditions risk.
Co-dependencies	Interest and support from potential partners.

4.1.7 Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University

Summary

Development of a continuous improvement capability embedded within the Trust.

Trust accountable lead: Anna Basford	**Trust responsible lead**: Catherine Riley

A	Objective 1: Drive performance improvements - better care for less.
B	Objective 2: Establish the Trust's strategy and service improvement roadmap.
C	Objective 3: Quantify the capital investment required and potential phased returns.

Activities
A Understand what is available in terms of training, fellowships and offerings from Health Education Yorkshire and Humber.
A Identify opportunities for change and realise benefits in areas such as equipment and discharge and control.
B Understand which staff would benefit most from the training and how the Trust could maximise its return on the investment.
B Identify priority areas for application by collating analytical performance and trend data, identified poor performance data and complaints reports.
B Explore funding opportunities and mutually beneficial arrangements with the Commissioners.
B Promote income from overseas.
C Understand and quantify the expected benefits of any such programme and form a realistic timescale for the benefits to be realised.

Benefits and cost

Financial	Non-financial
• £0.5m from equipment savings by streamlining to a single equipment library. • £190k saving by utilising a single discharge and transport control centre. • £30k increased income from overseas visitors.	• Staff empowerment. • Recruitment and retention opportunities. • Upskilling of staff.

Incremental capital outlay: None	**Incremental revenue cost**: Included in budget

Challenges

- A fellowship requires the employee to be released from day-to-day services whilst undertaking the fellowship. This poses an additional strain on the workforce and additional costs to cover the absence.
- Retention of trained and highly qualified staff.

Criteria

Quality of care	Improved. Increased clinical productivity.
Access to care	No change.
Value for money	Improved by reducing wastage and inefficiencies.
Deliverability and sustainability	High, but requires initial investment, increasing strain on workforce.
Co-dependencies	Compliments workforce skill planning.

4.1.8 Introduce innovative finance structures that enable savings

Summary

Funding and VAT optimisation for the Trust.

Trust accountable lead: Keith Griffiths	**Trust responsible lead**: Kirsty Archer

A Objective 1: Broaden understanding of the financial mechanisms available to the Trust.

B Objective 2: Implement a financial strategy that results in cost savings for the Trust.

Activities
A Learn from other Trusts and case studies to develop a shortlist of options available to the Trust.
A Explore opportunities via the PFI agreement in operation at Calderdale to make tax savings and reclaim VAT.
B Review the use of the joint venture, Pennie Property Partnership, that the Trust holds jointly with Henry Boot Developments

Benefits and cost

Financial	Non-financial
• Savings opportunities to be evaluated.	

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- Not applicable.

Criteria

Quality of care	No impact.
Access to care	No impact.
Value for money	Potentially high.
Deliverability and sustainability	Medium. May require renegotiation of existing contracts.
Co-dependencies	May require agreement with PFI provider.

4.2 Operational Initiatives

4.2.1 Identification of service development opportunities to ensure we maximise income for the Trust

Summary

Exploring opportunities to generate further revenue by increasing the Trust's market share.

Trust accountable lead: Anna Basford	**Trust responsible lead**: Catherine Riley

A	Objective 1: Grow the HPS pharmaceutical manufacturing unit.
B	Objective 2: Regain market share of orthopaedic electives, bariatric surgery, hand trauma and ophthalmology.
B	Objective 3: Increase offering of other services which will increase the Trust's revenue.

Activities	
A	Support development of pharmaceutical manufacturing unit.
B	Growth in orthopaedic electives performed at CHFT to regain 'a fair share' of the local market.
B	Increase elective T&O by 2.5% for Huddersfield and 10% for Calderdale.
B	Increase the number of bariatric surgery (11 per year), hand trauma (103 per year) and ophthalmology (160 per month via re-opening of out of area referrals) patients treated by the Trust.
B	Explore options for increasing the amount of private patient work performed by the Trust, capitalising on the new planned care centre.

Benefits and cost

Financial	Non-financial
• £0.6m incremental contribution from pharmacy manufacturing unit.	

Incremental capital outlay: £2.3m	**Incremental revenue cost**: Included in budget

Challenges

- Influencing referral pathways.
- Development of more compelling value proposition than a private service.

Criteria

Quality of care	No change.
Access to care	Increased elective options for patients in the region.
Value for money	Increased collections for activities performed.
Deliverability and sustainability	Easy to implement with immediate results. Securing more elective work may require persistence.
Co-dependencies	Complements the improved IT infrastructure.

4.2.2 Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction

Summary

Provide an efficient and cost effective operational inpatients and outpatient service by maximising utilisation of clinic resource and implementing benchmarking to monitor performance.

Trust accountable lead: Helen Barker	**Trust responsible lead**: Saj Azeb (Inpatients) **Trust responsible lead:** Rob Aitchison (Outpatients)

A Objective 1: Implement an inpatients service that minimises the variation within and optimises patients' LOS by timely and effective discharge. Use of external and internal benchmarks to measure success.

B Objective 2: Implement an outpatient and associated administrative process that:

- Reduce DNA and maximise the availability of new appointments and reduce unnecessary follow ups
- Optimise outpatient utilisation
- Reduce hospital cancellations and improve the patient experience.

C Objective 3: Expand ambulatory emergency care (AEC).

D Objective 4: Produce a bed model more reflective of patient need.

Activities

A Understand pathways across all inpatient services identifying opportunities to streamline.

A Undertake benchmarking by HRG to understand opportunities.

A Create systems that deliver effective patient flow.

A Implement discharge process that ensures no unnecessary patient delays.

A OP: Monitor performance and address problem areas linked to the use of internal and external benchmarking tools across outpatients.

B OP: Review the Trust's outpatient discharge rates and identify, with primary care colleagues, the opportunities for alternative models of follow-up.

B OP: Monitor demand and capacity to ensure new and follow-up patient appointments are able to meet requirements.

B OP: Explore opportunities to reduce the level of DNAs, including expansion of text messages alerts, other communication options, a self-booking portal and a method for reallocating appointments.

B OP: Implement a system to monitor clinic utilisation with any associated improvements required.

C IP: Profile admissions (time, condition, etc.) data to inform the Trust's strategy for ambulatory care, including operating hours.

C Participate, with the wider system, in the Emergency Ambulatory Care collaborative to redesign pathways, agree facility requirements (including workforce) to deliver a full ambulatory care service.

C Monitor re-admission rates for patients treated via ambulatory care pathways to establish ambulatory care's effectiveness and thereby identify opportunities to improve the pathway.

Benefits and cost

Financial	Non-financial
• £1.50m from a 6% medical LOS reduction. • £0.38m by starting patients on pharmaceutical interventions faster and hence reduce readmission • Best practice tariff repatriation resulting from enhanced ambulatory care offering. • Reduced bed base due to reduced LoS from enhanced use of ambulatory emergency care. • LOS reduction benefits from ambulatory care. • Overhead cost reductions from ambulatory care. • Changes to income models for in and out patients. • Savings from clinic reduction or increased income from re-allocation including job plan opportunities. • Potential requirement for increased out of hours clinical capacity.	• Greater accountability of clinical performance. • Improved patient experience. • Enhanced reputation for the Trust. • FFT and staff satisfaction surveys.

Incremental capital outlay: TBC **Incremental revenue cost**: TBC

Challenges

- Difficulties of implementing a whole system approach.
- Hard to reach demographics.
- Acceptance of primary and secondary care clinicians to pathway changes with agreement on associated governance.
- Education of clinicians and nurses regarding ambulatory care pathways.
- Challenging the risk adverse culture to facilitate further utilisation of ambulatory care.
- Estate implications of expanding AEC.

Criteria

Quality of care	Improved patient attendance and monitoring of performance.
Access to care	Increased patient throughput from reduced LOS.
Value for money	Reduced costs for outpatients.
Deliverability and sustainability	Align with Trust EPR strategy.
Co-dependencies	Aligned with reducing clinical variation.

4.2.3 Address clinical variation ensuring delivery of consistent, standardised evidence based care

Summary

Reduce unwanted clinical variation to deliver a more efficient, co-ordinated and cost effective service.

Trust accountable lead: David Birkenhead	**Trust responsible lead**: TBC

A Objective 1: Quantify and reduce unwanted clinical variation.

B Objective 2: Develop internal performance metrics and benchmarking tools in accordance with NICE evidence based care guidance and frameworks.

C Objective 3: Review and revise the clinical policies to ensure standardisation.

Activities

A Identify where instances of clinical variation arise from, including a drilldown analysis of performance by hospital, department, day of the week, etc. supported by EPR.

A Review the controls in place to monitor divisional spend on equipment.

B Introduce/expand the clinical audit program that has been developed to identify and address priority areas.

C Introduce standardised policies and guidelines for addressing clinical variation issues and ensure clinicians receive regular training regarding the latest guidelines.

C Review existing care bundles and develop more effective models.

C Standardise the policies and procedures across both Trust sites.

Benefits and cost

Financial	Non-financial
• 5% reduction in diagnostic tests.	• Consistent quality of care. • More efficient, co-ordinated service. • Improved staff knowledge and communication.

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- The role out of EPR may require clinical variation to be addressed in a different way that is consistent with the new system.

Criteria

Quality of care	Reduces unwanted clinical variation.
Access to care	No change.
Value for money	Improves clinical efficiency.
Deliverability and sustainability	Phased, long-term change.
Co-dependencies	Supported by IT, particularly EPR.

4.2.4 Workforce and skills planning;

Summary

The Trust can improve its staff skill-mix and workforce plan to meet current activity requirements effectively and provide a platform for growth.

Trust accountable lead: Julie Dawes	**Trust responsible lead**: Jason Eddleston

A	Objective 1: Create a workforce strategy.
B	Objective 1: Improve the skill mix of current CHFT staff through training and multi-skilling to enhance role resilience and flexibility.
C	Objective 2: Increase efficiency through improved rota management and agile working.
D	Objective 3: Ensure policy frameworks and controls are fit for purpose.
E	Objective 4: Consider collaboration with other organisations.

Activities	
A	Understand where workforce duplication occurs and quantify potential cost savings.
B	Identify options to multi-skill facilities staff to eliminate duplicate costs and increase rota flexibility.
B	Review the viability of increasing the number Advanced Care Practitioners and Advanced Therapist Practitioners to alleviate the pressure on current staff and reduce the need for locum.
B	Increase the scope and duties of ACPs and ATPs, for example orthopaedic procedures.
B	Explore the potential for developing and introducing generic assistants across the Trust.
B	Explore increased use of apprentices.
B	Consider multi-skilling Band 2 staff to take on increased responsibilities, e.g. therapy.
B	Consider training pharmacists and other allied healthcare professionals as prescribers.
C	Review consultants with more than 10 PAs.
C	Consider agile working options (such as remote working, tele-health and virtual clinics) to improve the efficiency of current staff.
D	Review policy controls to ensure they are fit for purpose and adequate to deliver the desired outcomes.
D	Appraise the viability of amending payment protection periods
E	Consider collaborations with other organisations to share back office functions.

Benefits and cost

Financial	Non-financial
• 2% efficiency improvement through the activities listed above. • Saving from multi-skilling band 2 staff estimated at £175k (facilities). • Initial training cost of £263k for ACPs over 2 years.	• Build staff resilience, flexibility and skill base. • Improve rota management. • Better use of current workforce.

Incremental capital outlay: None	**Incremental revenue cost**: Included in budget

Challenges

- Regulatory requirements and establishing correct levels of governance, training and accreditation for upskill training.
- ACP training is a five year process.
- Training is time and cost intensive, involves releasing trainees and supervisors from duties.
- Retention of highly skilled staff is challenging on a budget.

Criteria

Quality of care	Right governance and supervisory structure required.
Access to care	Improved flexibility of services.
Value for money	Improves efficiency of current resources.
Deliverability and sustainability	High capital investment.
Co-dependencies	Complements the reconfiguration of hospital services and adjustments required for 7-day working.

4.2.5 Reduce Bank and Agency use and deliver sustainable sickness absence reduction

Summary

Reduction of expenditure on locum staff beyond agreed to CIP levels to release funds for wider Trust improvements.

Trust accountable lead: Julie Dawes	**Trust responsible lead**: Jason Eddleston

A	Objective 1: Build on the activities of the CIP to drive further cost savings in locum spend.
B	Objective 2: Reduce staff absenteeism by 0.5%
C	Objective 3: Bring current locum spending within the new cap (being 55% of substantive staff costs).

Activities	
A	Quantify the successes and failures of the current CIP programme to identify further opportunities for cost reductions and also areas for improvement.
A	Consider and introduce temporary staff controls that augment those implemented via the CIP - apply across the full spectrum of Trust workforce. These controls may include stringent approval procedures for commissioning locum staff.
A	Produce a weekly dashboard that reports locum spend by cost centre and grade: Medical (Consultants, Junior, Middle), Nursing (Specialist, Ward, Ward managers), Allied Healthcare Practitioners, Admin and Estate/Facilities.
A	Monitor the additional spend for locums fulfilling vacant roles.
A	Revise the terms of locum staff. Consider implementing fixed term contracts when the forecast need for a locum is over an extended period.
B	Review the current sickness absence policy and consider disincentives for absenteeism.
B	Roll out ESR and Manager self-serve for improvement in capturing staff data and absenteeism.
C	Assess the potential for reducing locum by engaging Brookson Healthcare Services to arrange locum staff and reclaim VAT on exempt medical services.

Benefits and cost

Financial	Non-financial
• £768k saving in respect of Objective 2. • Stretch target for absenteeism reduction. • Reduced locum spend.	• Enhanced working environment and atmosphere. • Improved teamwork through familiarity.

Incremental capital outlay: None	**Incremental revenue cost**: Included in budget

Challenges

- Recruitment of substantive staff to replace locum.
- Changes in culture to reduce sickness and improve retention.
- Working with locum and agency providers to secure staff within the Monitor cap (being 55% of substantive staff costs).

Criteria

Quality of care	Improved, where locums replaced by bank and substantive staff.
Access to care	No change.
Value for money	Potentially high.

Deliverability and sustainability	Moderate. Depends on availability of skilled workforce in LHE whilst maintaining a level of temporary staff.
Co-dependencies	Reliance on neighbouring Trusts supporting locum cost cap.

4.2.6 Enhancing productivity of community work

Summary

Challenging working practices to deliver more for less from the Community team. Agile working that facilitates the workforce attending to patients in the community and consequently reduces the pressure on the hospitals.

Trust accountable lead: Helen Barker	**Trust responsible lead:** Mandy Gibbons-Phelan

A Objective 1: Achieve an increased number of visits per day per staff member.

B Objective 2: Introduce agile working to improve efficiency.

C Objective 3: Increase the number of patients seen in a community clinical setting from 30% to 40%.

D Objective 4: Working with the Vanguard to explore opportunities for alternative bed models within the community.

Activities

A Identify and bridge infrastructure and IT gaps that inhibit community operations.

A Develop clear criteria for a housebound policy and establish guidelines for home visits.

A Alignment and streamlining of community patient pathways to avoid duplication and support cost savings.

B Provide staff with mobile access to patient records, thereby reducing staff travel time and expenses.

C Reduce home visits by arranging for patients to be seen in a community clinic setting.

D Explore the introduction/expansion of a virtual ward[15] to reduced admissions and reduce LOS.

Benefits and cost

Financial	Non-financial
• £50k from a reduction in community staff travel expenses by co-ordinating home visits more effectively. • Increase in community productivity across Band 7 Allied Health Professionals and Band 6/7 Nursing and Midwifery staff.	

Incremental capital outlay: None	**Incremental revenue cost**: None

Challenges

- Reduced revenue

Criteria

Quality of care	No change.
Access to care	Increased ability to access the Community team.
Value for money	Potentially high – more for less.
Deliverability and sustainability	High for working practice days
Co-dependencies	Availability of IT and estate.

[15] This assumes no incremental community facilities

5. Overall expected benefits

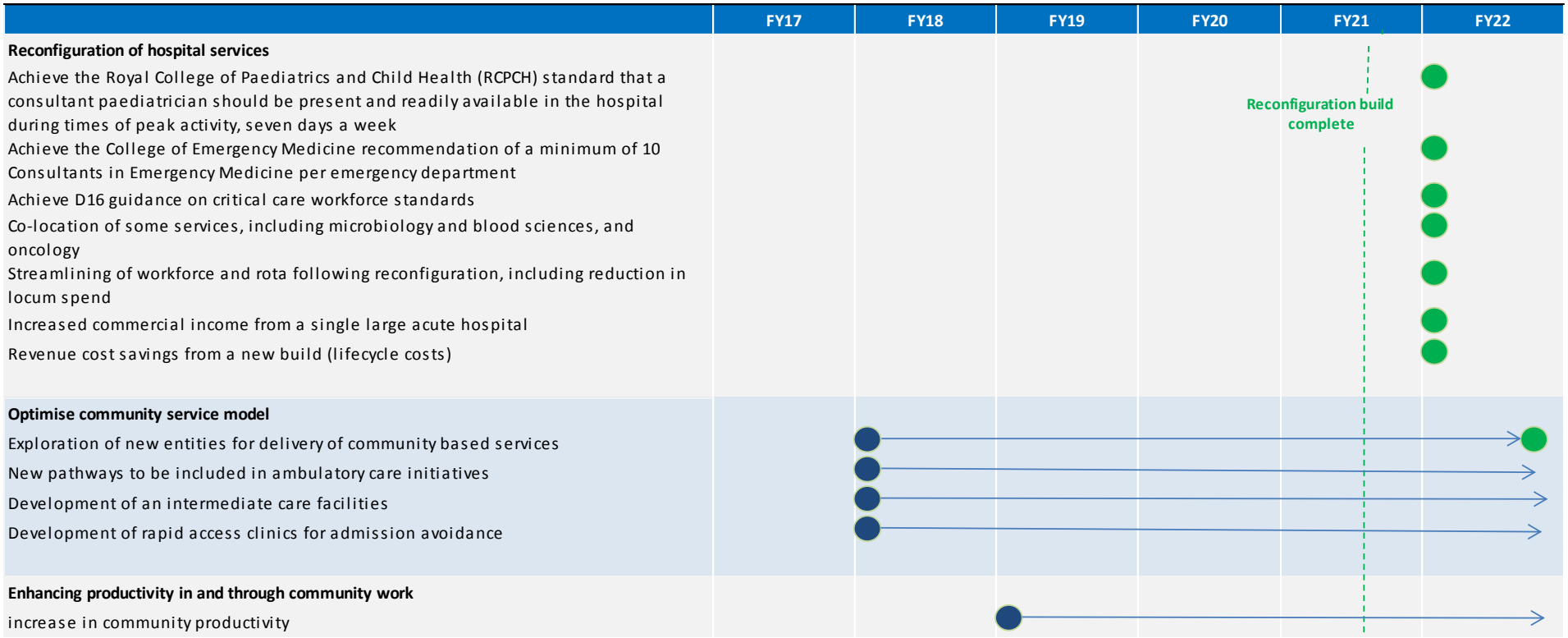
The strategic plan directly supports CHFT's strategic objectives, delivering benefits for patients, staff, the Trust and the local health economy

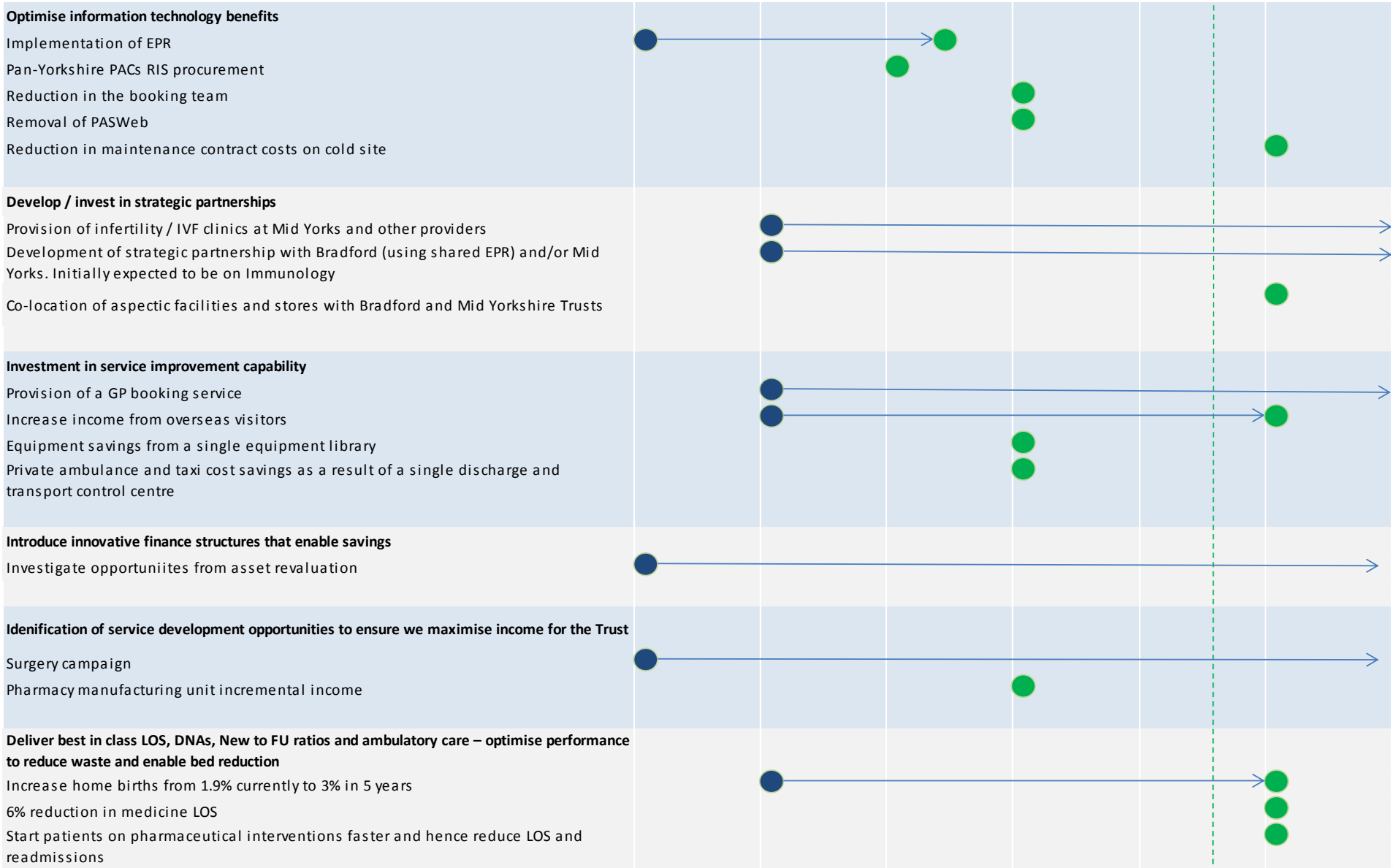
- For patients, there will be:
  - **Access to clinically sustainable unplanned care services.** The Trust will be able to meet current and expected clinical guidelines for the provision of safe and high quality services, with the ability to better provide emergency and other clinical cover.
  - **There will be reduced agency and locum use,** improving patient satisfaction.
  - **Access to a dedicated centre for planned care,** reducing cancellations and length of stay.
- For staff, there will be:
  - **An improvement in clinical cover and rota frequency/ intensity, improving recruitment and retention** supported by a comprehensive workforce strategy. Improving staff satisfaction will mean that a more positive workforce is able to deliver better quality care.
  - **The opportunity to develop new skills, and take on new roles.**
- For the Trust, there will be:
  - **An improved financial position** through optimisation of the estate
  - **Realisation of £25.4m (nominal) in strategic annual savings across the Trust**, with further potential benefits from the clinical reconfiguration.
- For the local health economy, there will be:
  - **Redesigned care pathways** to enhance quality, reduce ED admissions and appropriately manage lengths of stay, particularly for older people.
  - **Achievement of commissioner priorities,** as the reconfiguration is well aligned with local commissioners' objectives. This includes a net reduction in the acute bed base of 77 beds, reflecting a shift of activity into a community setting.

5.1 Key benefits

The fifteen initiatives will enable the Trust to direct its reconfiguration and consequently improve its future sustainability. Many of these initiative activities will involve reconfiguring multiple services over many years but not all are directly linked with reconfiguration. The table below details the proposed time frame for each initiative and the activities each initiative incorporates:

5.2 Timeline of when benefits are expected to be realised




Optimise information technology benefits
Implementation of EPR
Pan-Yorkshire PACs RIS procurement
Reduction in the booking team
Removal of PASWeb
Reduction in maintenance contract costs on cold site
Develop / invest in strategic partnerships
Provision of infertility / IVF clinics at Mid Yorks and other providers
Development of strategic partnership with Bradford (using shared EPR) and/or Mid Yorks. Initially expected to be on Immunology
Co-location of aspectic facilities and stores with Bradford and Mid Yorkshire Trusts
Investment in service improvement capability
Provision of a GP booking service
Increase income from overseas visitors
Equipment savings from a single equipment library
Private ambulance and taxi cost savings as a result of a single discharge and transport control centre
Introduce innovative finance structures that enable savings
Investigate opportuniites from asset revaluation
Idenification of service development opportunities to ensure we maximise income for the Trust
Surgery campaign
Pharmacy manufacturing unit incremental income
Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction
Increase home births from 1.9% currently to 3% in 5 years
6% reduction in medicine LOS
Start patients on pharmaceutical interventions faster and hence reduce LOS and readmissions

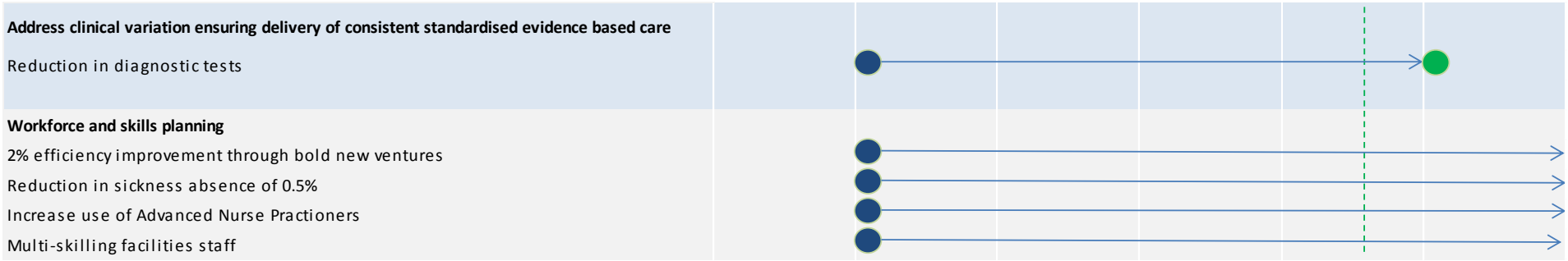


Figure 11: Expected benefits timeline

6. Timeline for implementation

A high level timeline for implementation has been developed over the 5 years to FY22, with key delivery milestones, covering both the proposed service reconfiguration and priority initiatives.

- **The high level timeline is primarily dictated by the proposed service reconfiguration.** This assumes:
  - Completion of Commissioner led consultation in Q2 of FY17
  - Completion of planning and design by Q1 of FY18
  - Contract award for the build by the end of Q4 of FY18
  - Completion of the build by Q4 of FY21
  - In parallel with this, all divisions will be undertaking preparatory steps ready for go-live
- **In addition to service reconfiguration, there are a number of more immediate initiatives to be taken forward.** These are primarily associated with improving efficiency and/or reducing cost.
- **Successful delivery against the timeline will be provided through two core governance structures – one internally facing and one externally facing**. Internally, a dedicated Programme Director and Programme Board is proposed, reporting in to the Trust Board to deliver the 15 priority initiatives. Externally, a Joint Working Group will ensure alignment between the Trust, commissioners, regulators, local authorities and other providers**.**
- **This high level timeline has been developed bottom-up from milestones developed by each division** and captured in the implementation plan, and division specific Gantt charts.

CHFT understands the challenge, time and resource it will take to effectively implement its 5 year strategic plan, a key component of which is delivering the proposed model of care for hospital services through reconfiguration. Designing an appropriate implementation strategy is crucial to the success of the 5 year strategic plan and all the initiatives which underpin it.

An implementation plan that maximises the benefits of strategic initiatives, including but not limited to reconfiguration, without jeopardising 'business as usual' has been developed. It is vitally important that all implementation planning is geared towards realising the strategic goals and projected benefits for the future state Trust model.

The implementation planning process considers two key types of activity: those which are directly linked with reconfiguration and those which should take place irrespective of reconfiguration.

Whilst some implementation activities may not be able to start until a full public consultation and a definitive decision is made regarding reconfiguration, the following core activities will be undertaken as early priorities:

- Establishment of implementation governance arrangements;

- Transparent and appropriate planning of workforce;
- On-going stakeholder engagement; and
- Development of divisional implementation and transition plans.

One of the key components required to ensure the successful delivery of the Trust's 5 year strategic plan is establishment of a robust programme governance structure with strong inputs into and outputs from divisional governance arrangements. Divisions and specialties will have responsibility for developing, implementing and evaluating divisional-specific strategic initiatives and the necessary activities to enable the Trust to successfully reconfigure. However, there must be a clear, comprehensive and rigorous approach to ensuring that there is a robust balance between a centralised versus devolved approach.

A description of the programme governance structure is included in the next section of this document.

6.1 Development of the programme timeline

In the course of the work undertaken to develop, refine and articulate the Trust's 5 year strategic plan in collaboration with divisions and other key service lines, a high level divisional implementation plan was agreed with each area. The key milestones from these divisional plans (shared in section 4 of this document) were then used to create an overarching programme timeline which captures the highest priority areas for implementation over the 5 year time horizon. The programme timeline overleaf identifies:

- When an activity is expected to be completed by
- Where there are critical interdependencies

It should be used to provide an overarching structure to the management of the programme and from which more granular, SMART –oriented plans should be developed

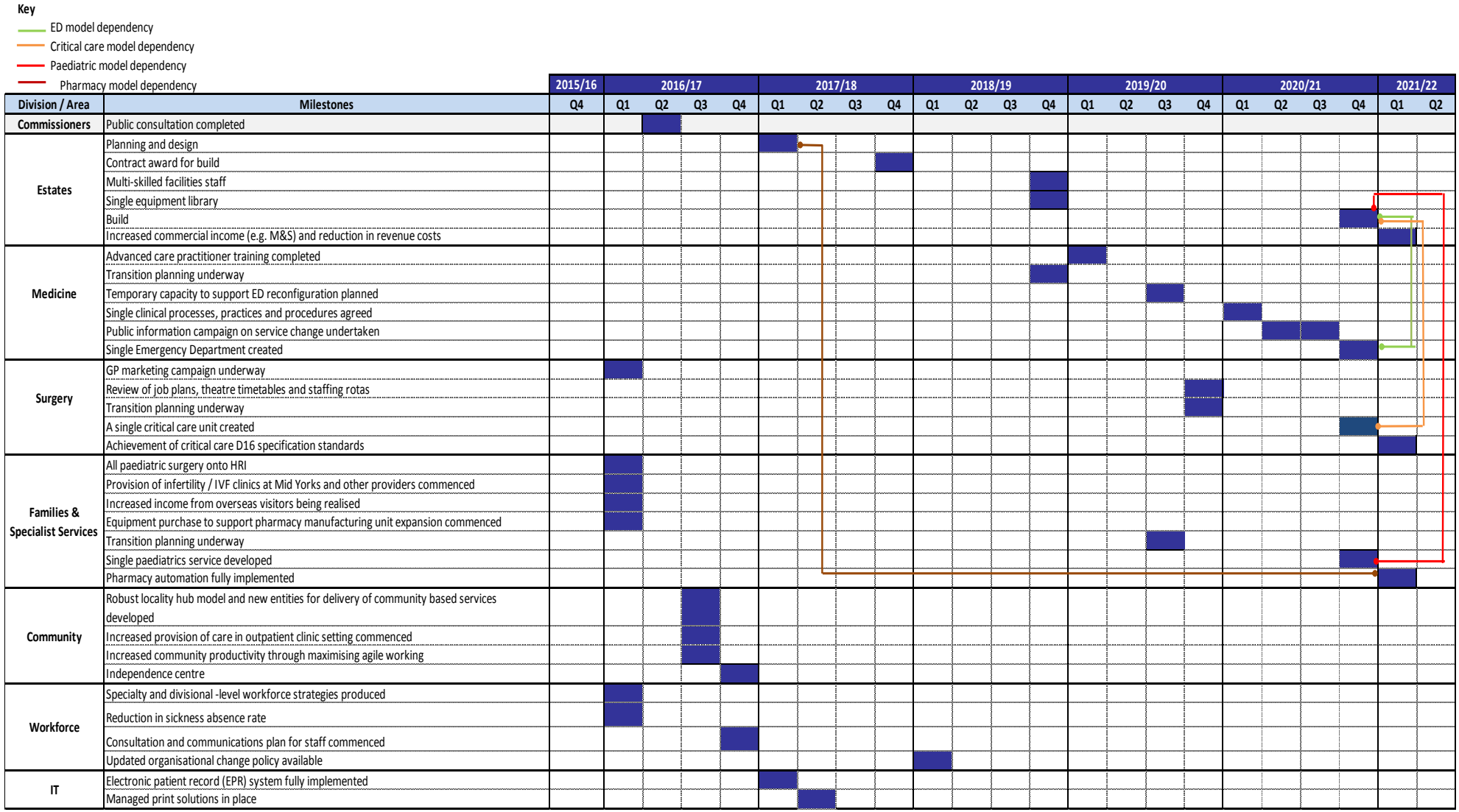


Figure 12: Timeline for implementation

The governance to ensure robust delivery will be delivered through two routes. Firstly, an internal structure that ensures rigour across internal Trust delivery. Secondly, an externally facing governance structure that ensures alignment across stakeholder groups – both local and national.

The internal structure centres on a delivery matrix which forms the core delivery mechanism for the programme. Delivery of the priority initiatives (vertical axis) will run across the divisions (horizontal axis), with the most appropriate accountable and responsible delivery leads leading each initiative as identified in the shortlist of five year strategic plan initiatives. This will be overseen by a dedicated Programme Director and Programme Board, reporting into the full Trust Board as demonstrated in figure 14 overleaf.

The external structure will provide alignment between the Trust, commissioners, regulators, local authorities and other providers in delivery.

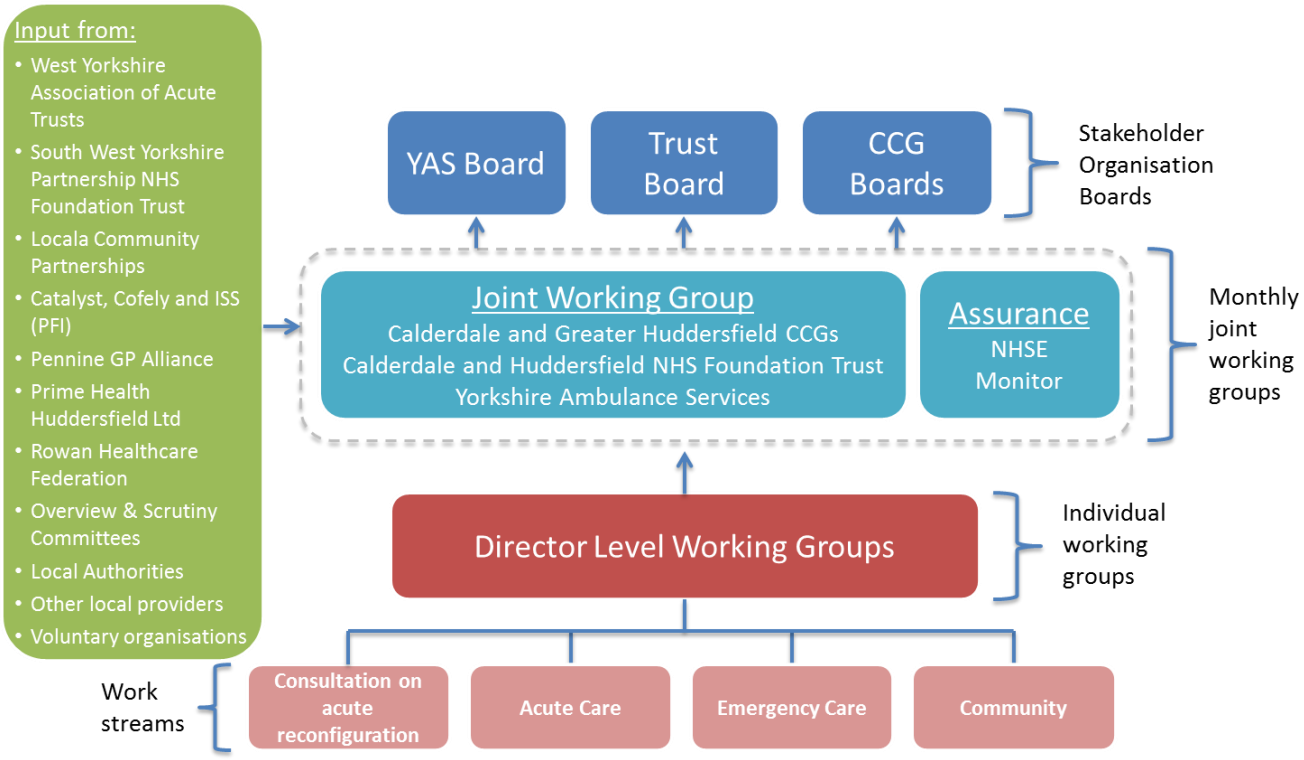


Figure 13: External governance structure

Further detail on both of these is given in the supporting 5 year implementation plan

Programme Director
The Programme Director provides leadership to the Programme and is the first point of escalation to resolve issues captured by the PMO (Programme Management Office).

Trust Board
Trust Board will be held accountable for the overall delivery of the Programme.

Programme Board
Programme Board will focus on decision making, key issue resolution, agreeing priorities and driving pace and traction in delivery.

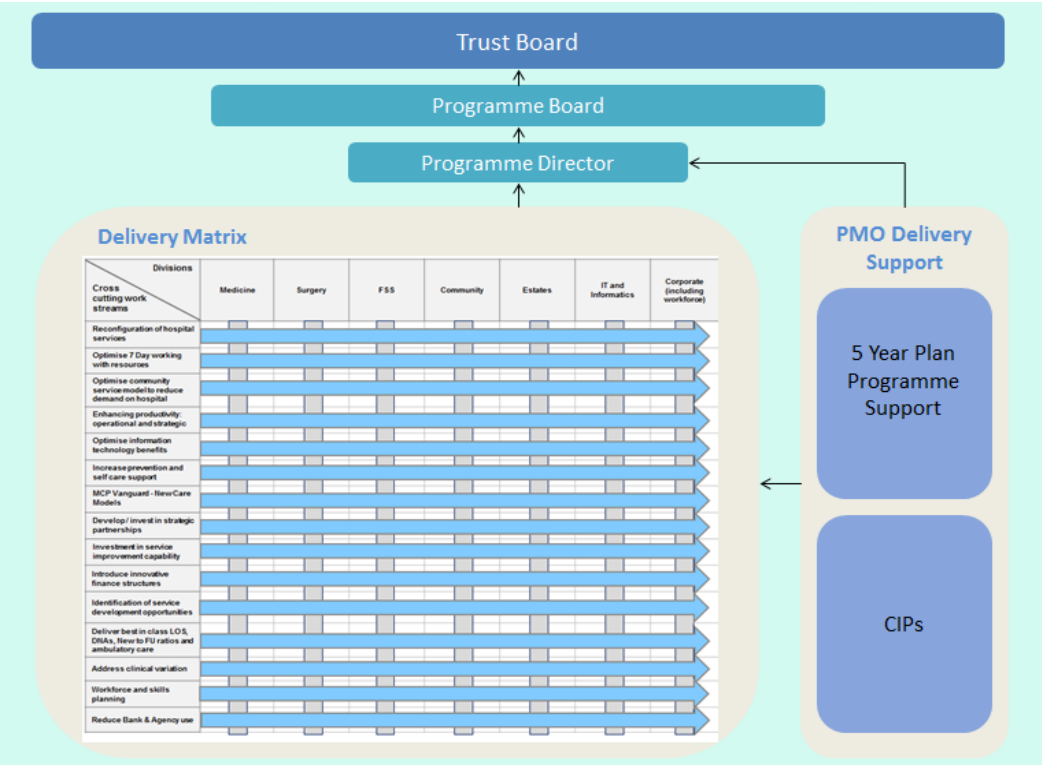
Delivery Matrix
The delivery matrix forms the core delivery mechanism for the programme.

Each of the priority initiatives identified in the Trust's 5 year plan will have a working group tasked with driving forward the design and delivery of activities required to successfully realise the expected benefits associated with each initiative. Working groups will meet at least monthly.

Each of the priority initiatives, and hence each working group, will have a Trust accountable lead with overall responsible for delivery. The Trust accountable lead will be a Director sponsor whose role will include setting the direction of travel for the initiative and reporting on progress to the Board.

Each priority initiative will have a Trust responsible lead whose role includes being overall responsible for the delivery of activities underpinning the initiative. The Trust responsible lead will chair the working group.

Each working group will have appropriate representation from each division (representatives will be selected by the divisional management teams).



PMO
The Programme Director will be supported by a PMO whose role will include:

- Co-ordination of the Trust's implementation plan
- Overall management of the programme
- Identification and documentation of issues that may require escalation to the Programme Director and/or the Programme Board.

The PMO is split into two groups, programme support and CIPs. The programme support function will primarily facilitate delivery of implementation specific activities at divisional and Trust wide levels.

The CIPs support function will consist of individuals assigned to different tactical/ strategic schemes which form the Trust's CIP plan for the year.

The key function of the PMO is to drive issue resolution rather than excessive reporting

Figure 13: Internal governance structure

N.B. The Turnaround Executive will continue to be accountable for the management and quality impact assessment of cost improvement programmes (CIPs)

7. CIP plans

The Trust is expecting to outperform CIP targets for FY16 and has made strong progress in identifying CIP plans for FY17.

- **The Trust is expecting to deliver £17.6m of savings in FY16** against a revised target of £17.2m.
- **£13.9m of schemes have been identified for FY17,** with ongoing work to identify further saving opportunities.
- **In aggregate the Trust will need to make £54.4m of CIP savings in addition to the £25.4m of strategic savings between FY17 and FY22** (nominal).
- The Trust has an established governance process with **executive sponsorship of each of the schemes and dedicated PMO support** including support to the quality impact assessment process.

7.1 Historic delivery of CIP

In FY14, the Trust set a target of £16.1m for in year delivery of CIP. This was beyond the expected 4% efficiency requirement at 4.6%. The Trust was able to deliver savings of £11m representing 68% of the target and 3.1% of annual turnover.

In FY15, the Trust set a target of £19.5m for in year delivery of CIP. This was beyond the expected 4% efficiency requirement at 5.6%. The Trust was able to deliver savings of £9.4m representing 48% of the target and 2.7% of annual turnover.

Following previous underperformance against CIP targets, the Trust implemented a PMO with external support to assist.

As a result of the re-focussed approach on CIP and the need to move towards recovery following a breach of license in January 2015, the Trust set a target of £14m for CIP in FY16. This target was revised to £17.2m as part of the Trust's recovery plans and is expected to delivery £17.6m by year end.

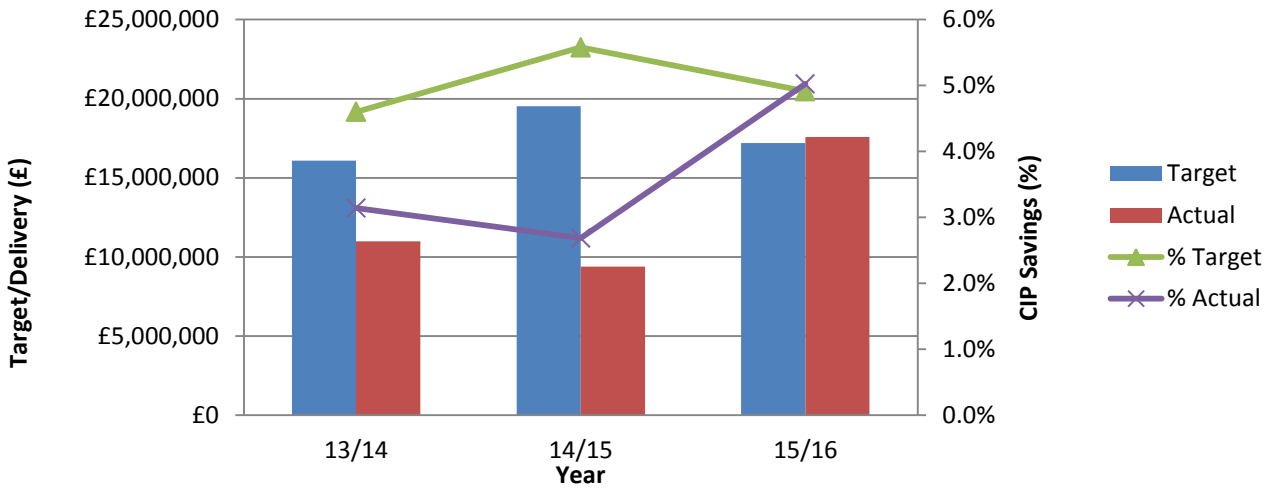


Figure 14: CHFT CIP delivery against target

7.2 Future CIPs

The current value of schemes identified on the FY17 CIP tracker is £13.9m with £13.6m included within the financial forecast. The Trust has a strong governance process that has been independently reviewed. £2.1m of the CIPs are fully progressed through the approval process with the remaining schemes expected to follow before March 2016.

As part of the ongoing development of the CIP governance process, the Trust has moved to a portfolio based approach. Each division within the Trust is responsible for delivery of CIPs within their division, but there is also accountability at an executive leadership level with each portfolio having an Executive sponsor as well as dedicated PMO support.

The table below sets out the different portfolios and a breakdown of the current progress on identifying cost reduction schemes for FY17. Circa £6.6m of this figure (circa 47%) are income schemes. N.B. The FY17 position is subject to change and the figures below are correct as of 8th December 2015. The Trust is seeking to increase the focus on cost reduction schemes relative to income.

£000s	FY16	FY17	FY18	FY19	FY20	FY21
Other staffing groups	2,607	1,150	-	-	-	-
Nursing workforce	1,681	498	-	-	-	-
Theatres productivity	842	1,100	-	-	-	-
Operational productivity	981	1,649	-	-	-	-
Growth and contribution	3,897	5,293	-	-	-	-
Non-pay	1,360	500	-	-	-	-
Medicines management	319	288	-	-	-	-
Estates and facilities	168	815	-	-	-	-
Clinical Standardisation	150		-	-	-	-
Medical Workforce	-	250	-	-	-	-
Business process re-engineering	-	1,500	-	-	-	-

£000s	FY16	FY17	FY18	FY19	FY20	FY21
Integrated care and community	-	879	-	-	-	-
Divisional Schemes	5,594		-	-	-	-
Total	**17,599**	**13,922**	-	-	-	-
Target	**17,200**	-	-	-	-	-

Table 4: CHFT CIP portfolio

Between FY18 and FY22, CHFT will need to identify cost reductions amounting to £40.8m (nominal), or £54.4m including FY17. This is required to offset the annual efficiency requirement but also to mitigate the impact of QIPP based income reductions. This will need to be reviewed in light of any changes to tariff as it becomes available.

The table below outlines these savings by year from FY18-FY22, shown in nominal terms.

£'m (nominal)	FY18	FY19	FY20	FY21	FY22	TOTAL
CIP	8.2	7.0	7.0	9.3	9.3	**40.8**
QIPP	2.8	2.7	2.6	2.5	2.4	**13.0**
TOTAL Business as usual savings	11.0	9.7	9.6	11.8	11.7	**53.8**
% Business as usual savings of operating costs	3.1%	2.8%	2.8%	3.5%	3.5%	

Table 5: CHFT CIP targets

7.3 Governance

An independent review of the Trust's governance process found that the process was good but required improvement in some areas. These have been taken on board and are being implemented where appropriate.

For FY17, CIP schemes have been categorised into 12 portfolios. For each of these portfolios there is a project team. The Project Team is an **internal** function made up of an executive sponsor, clinical lead, project lead and project manager. The roles and responsibilities of these individuals are as follows:

- **Executive Sponsor**
  - Overall accountability for the delivery of the project
  - Holds the Project Manager, work stream Lead and Clinical Lead to account for their role in delivery
  - Approval of project scope and approach through formal workbook sign off
  - Provide ongoing leadership, direction and guidance
  - Unblocking and resolution of issues where Executive support needed (e.g. Senior decision making, Stakeholder engagement, deployment of resources)
- **Clinical Lead**
  - Provide overall direction and assurance on clinical impact of project

- Contribute to project development and sign off from a clinical perspective
- Ongoing monitoring to ensure a clinically safe and appropriate approach to project delivery
- Promoting ownership and buy-in from clinical colleagues to achieve change
- Support to Project Manager where senior Clinical support is necessary

- **Project Lead**
  - Provide overall direction in line with work stream objectives
  - Oversee delivery and provide guidance and leadership to the Project Manager
  - Ensure that plans are suitably ambitious, comprehensive and robust Support engagement across all stakeholders and ensure harmonised implementation
  - Report into and influence work stream board and steering group
  - Escalate issues to the Executive Sponsor as appropriate
- **Project Manager**
  - Responsible for day to day operational management and delivery of the project
  - Produce project plan with input from relevant stakeholders
  - Identify and manage project team and stakeholder inputs
  - Monitor and manage progress against plan ensuring expected benefits, target KPI's and scope and objectives are met
  - Proactively addresses issues escalating to Executive Sponsor as appropriate
  - Ongoing liaison with the PMO and reporting on progress at regular PMO review meetings

The Project team as a whole is responsible for the implementation and delivery of CIP plans by the means of structured planning, decision making and reporting. They will report to the PMO, on a weekly basis to update on the progress of CIP Project Plans and flag any variances to the PMO on an exception basis.

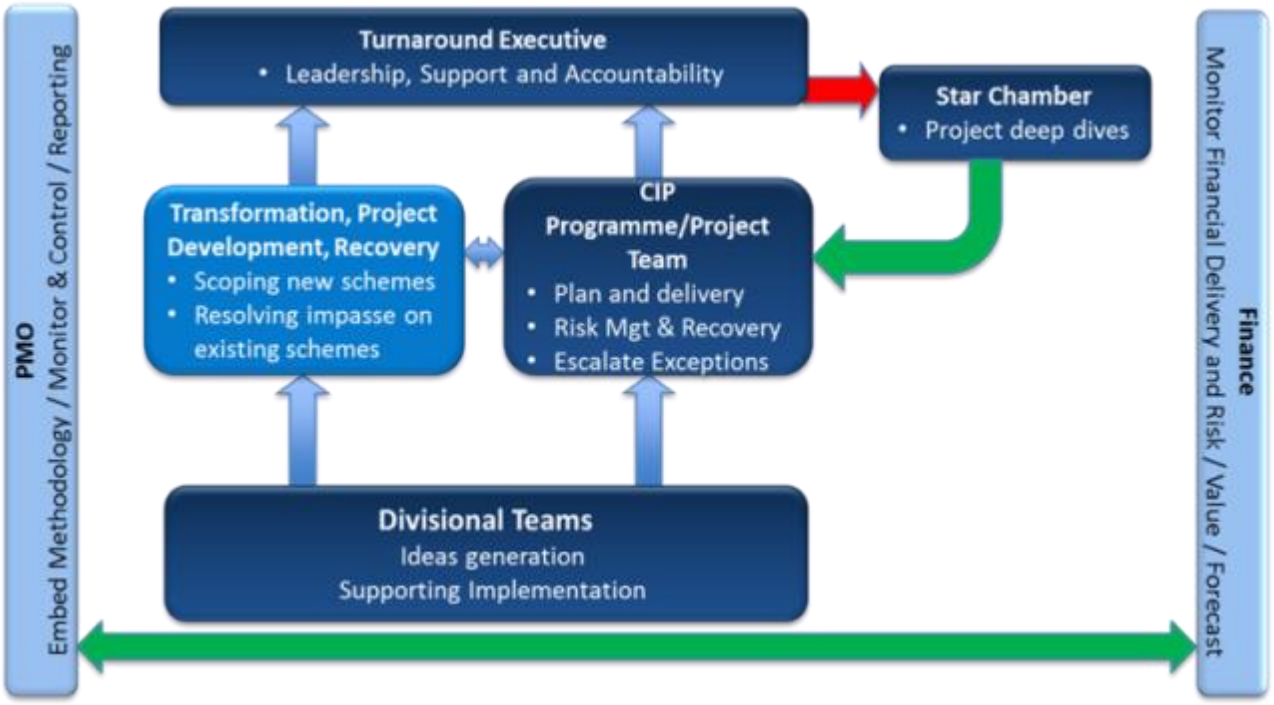


Figure 15: CHFT CIP reporting and governance structure

7.3.1 Quality Impact Assessment (QIA)

In addition to the governance above, all CIPs will be taken through a Quality Impact Assessment process. The purpose of the QIA is to provide assurance that all risks to quality and performance have been considered at the planning stage of any service change and periodically refreshed throughout the business cycle. This will ensure that the impact of the service change on quality and performance will be accurately assessed and managed.

The QIA process involves an initial assessment (gateway 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

Gateway 1 Initial QIA is to be completed at the scoping stage for all projects in order to progress through Gateway 1. Key Stakeholders will provide scrutiny and comments on the QIA prior to review and approval by a nominated Clinical Lead. For Gateway 1, quality is split into 5 categories to be individually considered.

Gateway 2 QIA is to be fully completed at project planning and development stage for all projects in order to pass through Gateway 2. The QIA should be completed and reviewed alongside completion of the Project Workbook to reflect the latest intelligence available at the time. All quality risks should have mitigating actions that should be clearly demonstrated in the Milestones tab or have KPI's linked to them. Key Stakeholders will provide scrutiny and commentary on development of the QIA prior to review and approval by the Exec Sponsor and Clinical Lead. The scheme is then ready for review at the Trust's Quality Panel.

Quality Panel approval: The Quality Panel is headed by the Director of Nursing. It consists of a panel of key staff made of a minimum of 3 of the following: Director of Nursing, Associate Director of

Nursing, Medical Director, Infection Control Nurse, Divisional Director, Consultant, Non-Exec Directors, Membership Counsellor, Expert Patient, Matrons.

The panel is convened when projects or programmes require sign off. The Project Lead attends the panel to answer queries. Following review, the panel will make one of three recommendations:

1. Project approved for mobilisation
2. Project approved following the recommended changes being made
3. Project not approved. The project could re-submit following major review or project stopped.

Ongoing monitoring of quality risks and metrics as defined in the Gateway 2 QIA will be reported via the project team and PMO Dashboard process to the Exec Sponsor and Turnaround Executive.

8. Case for change and future case

8.1 Clinical

There is a compelling opportunity to implement a clinical model of care that will enhance delivery of acute services in accordance with best practice standards for care and patient experience.

- **The Trust is not able to provide a sustainable clinical model of provision across two Emergency Departments (EDs). This impacts on the safety and outcomes that can be achieved.**
  - The College of Emergency Medicine recommends a minimum of 10 Consultants in Emergency Medicine per department. Currently there are 5 in Halifax and 5 in Huddersfield – two Emergency Care Departments within a distance of only 5 miles.
  - The two EDs in Halifax and Huddersfield require a rota of 12 speciality doctors. In the last 5 years there has only been a maximum of 7 doctors with gaps in the rota filled by locum staff.
  - The Trust's high level of concern with regards to continued delivery of services has resulted in the Trust developing a contingency plan should there be an urgent need to temporarily close one of the ED sites. This has been shared with local CCGs, overview and scrutiny committees and Monitor.
- **The Trust is not currently able to substantively recruit to meet the rotas of the two sites.**
  - A number of recruitment processes have failed due to lack of applicants. The turnover of medical staff in the Trust is increasing with Consultant staff exiting the Trust in Emergency Medicine and other Medical specialties.
  - The reason given for their departure is the current configuration of Trust services across two sites. This compromises the quality of care that can be provided, and impacts on workload and frequency of on-call responsibilities i.e. a 1:5 consultant on-call commitment in Medicine and Emergency Medicine.
- **The Trust is not compliant with many standards for Children and Young People in Emergency Care settings.**
  - Currently the two Emergency Departments at Halifax and Huddersfield are non-compliant with many of the standards as described in standards for Children and Young People in Emergency Care settings. A particular challenge at present includes ensuring a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.
- **The Trust's HSMR and SHMI is above the national average.**
  - The Trust will be able to improve clinical safety by addressing dual site working (for example, through reducing the need for medical transfers and through reducing medical outliers).

- **As part of a whole system approach, a clinical model underpinning the future model of care for hospital services in Calderdale and Greater Huddersfield has been developed.** The proposed model of care would address the sustainability issues above, strengthening the care and quality received by patients.
- **This model of care proposes co-location of planned care services, and unplanned care services.** There is strong evidence that the proposed model of care will deliver clinical benefits. In particular, through improvements in paediatrics, emergency medicine and critical care staffing, as well as more general quality benefits from service co-location. This model has also been endorsed by the Yorkshire and Humber Clinical Senate.
- **No degradation of any existing services is anticipated as a result of the proposed model**. Some services may change the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model.
- **A set of modelling assumptions has been developed by the Trust to evaluate the capacity required by the Clinical Model.** These assumptions imply that:
  - Depending on the site option, a total bed base requirement of 732-734 beds after 5 years is required (608-612 on the unplanned care site and 119 - 126 on the planned care site).
  - A total theatre requirement of 18 theatres after 5 years is required (8 on the unplanned care site, and 10 on the planned care site).
  - That reconfiguration will have a modest, but material, impact on neighbouring providers.
- **Crucially, the bed capacity on the unplanned care site is strongly linked to the delivery of significant reductions in non-elective medical demand – equivalent to 6% per annum.** This is reliant on CCGs leading development of innovative and effective models of care closer to home. Failure to achieve this runs the risk of the hospital having insufficient capacity to support demand.

8.1.1 The clinical vision

The Trust's vision and values ensure that the work it carries out always 'puts the patient first'. The overall vision for the Trust is strongly patient and clinically focussed, and provides the context for the current and future clinical and operating models:

"Together we will deliver outstanding compassionate care to the communities we serve"

It is delivered through 4 key goals focussed on the following:

- Transforming and improving patient care
- Keeping the base safe
- Developing a workforce for the future
- Achieving financial sustainability

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
By this we mean	Our SHMI will be 100 or less	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape & size with the capability & capacity to deliver safe, high quality services in our hospitals & wider community ; maintaining safe staffing levels 24/7.	We will have implemented the five year plan
	We will have fully implemented an agreed re-configuration of integrated hospital and community services	We will be compliant with all Monitor requirements	We will be widely recognised as an Employer of Choice, attracting talented & committed people to join our team.	We will be financially sustainable with the ability to invest for the future
	We will meet all 7 day working standards	We will consistently achieve all national and local targets	We will actively engage with our people involving them in decisions that affect the Trust, teams and individuals.	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust electronic patient record	We will be fully compliant with health and safety standards	We will invest in the health and well-being of our people, improving attendance and availability to ensure safe services 24/7	
	Our patients and the public will be involved in their treatment and we will use their feedback on services	Our estate will be fit for the future	We will embed a fully integrated approach to the development of our people, building a community of value driven senior leaders and promoting visible and supportive leadership at all levels of the organisation.	

Figure 16: CHFT 5 year strategy and vision

This vision is built on putting patients first and the Trust's core values which all employees are expected to follow, specifically:

Figure 17: CHFT employee behaviours

Underpinning the Trust's core strategy are the following specific patient care improvement objectives:

- Reduce mortality rates in hospital
- Improve patient experience and safety
- Provide better care for less cost
- Reduce the number of unnecessary emergency admissions
- Improve patient flow and reduce hospital unnecessary waits for care
- Provision of more out of hospital care

The overall vision for the Trust aligns with that of the local commissioners, the wider local health economy and the overall vision for the potential outline future model of care for hospital services[16] in Calderdale and Greater Huddersfield. These are based on a principle of delivery of the right care at the right time in the right place and ensuring that local populations can live longer, healthier lives.

The Trust's 5 year strategy will focus on delivery of high quality care 24 hours a day, 7 days a week through service transformation and reconfiguration. This will be facilitated by optimising the deployment of clinical staff and patient to clinical staff ratios to improve safety, service quality, experience and outcomes for patients. A key enabler of this will be development of joint care pathways with partners to ensure seamless care is delivered in primary, community care and third sector settings.

8.1.2 Current clinical services

CHFT provides acute services at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). These services are in addition to the anticoagulation services and primary care discharge co-ordination services with the 2 GP Federations in Huddersfield (Rowan and Prime Health Huddersfield) and the Trust being the community services provider for Calderdale. Some acute services are provided at both sites whilst others are already provided on a single site as demonstrated by the table below.

Table 6: Current provision of services at CHFT

Service	At HRI?	At CRH?	Notes
AMU / Ambulatory / SSU	✓	✓	Whilst there is onsite consultant presence at HRI for General Surgery, where all non-electives are admitted, there is no resident Consultant for the adult medical specialties beyond 5pm
Cardiology	✓	✓	All interventional work is centralised on the CRH site
Respiratory	✓	✓	The respiratory team do not have a 7-day rota therefore there is no routine consultant review of patients on a weekend
Gastroenterology	✓	✓	The gastroenterology team do not have a 7-day rota therefore there is no routine consultant review of patients on a weekend

[16] Otherwise known as the Clinical Consensus Model v1.1 19th October 2015, supporting the commissioners' 'Right Care, Right Time, Right Place' programme

Service	At HRI?	At CRH?	Notes
Stroke	X	✓	Acute stroke unit is located at CRH along with stroke rehab services.
Elderly Care	✓	✓	Aspects of elderly care are provided in the community and recent initiatives such as Quest for Quality will ensure geriatrician input into nursing homes
Diabetes	✓	✓	Some outreach clinics are undertaken. Patients with diabetes who are inpatients tend to have on average an extended LOS by 2 days no dedicated in-reach structure at the moment
Oncology	✓	X	All acute oncology beds based on the HRI site. Chemotherapy and oncology outpatients on both sites.
Haematology	✓	X	Inpatient bed base at HRI, with 7 day a week ward cover available if needed. Outpatients at HRI
Neurology	✓	✓	Neurology input available on both sites but no specific inpatient beds. Outpatients on both sites
Rheumatology	✓	✓	Minimal outreach clinics undertaken at the moment.
Dermatology	✓	✓	Outpatient services provided from both sites with ward cover provided as necessary.
Inpatient Paediatrics	✓	✓	
Outpatient Paediatrics	✓	✓	
Inpatient Gynaecology	X	✓	
Outpatient Gynaecology	✓	✓	
Assisted Conception	X	✓	
Maternity – obstetrics	X	✓	
Maternity – midwife led	✓	✓	
Maternity – home care	X	X	
Orthopaedic trauma	✓	X	
Elective orthopaedics	✓	✓	Main elective surgery provided at CRH with spinal electives at HRI
Surgical assessment unit	✓	X	Patients referred from ED and directly from GP's
Vascular surgery	✓	X	Services provided within a network with Bradford and Airedale, so on "take" for all unplanned care cases 1 week in 2. So emergency surgery 1 week in 2 over 7 days

Service	At HRI?	At CRH?	Notes
Urology	✓	X	Ward 22 at HRI undertakes planned and unplanned surgery planned surgery over 5 days. O/P both sites Day Case and Endoscopy on both sites.
Unplanned General Surgery plus all planned and unplanned complex colo-rectal, upper GI, and bariatric surgery	✓	X	
Planned General Surgery excluding complex (See above)	✓	✓	
Critical Care	✓	✓	
Endoscopy	✓	✓	
ENT and audiology	✓	✓	Inpatient base in CRH in 8c – number vary as a mixed speciality ward. Audiology both sites
Ophthalmology and orthoptics	✓	✓	Inpatient base in CRH 8c. Vast majority of procedures carried out in an outpatient setting
Pain	✓	✓	Majority of procedures centralised at CRH through pain department, day case
Maxillofacial	✓	✓	GA procedures provided through day procedures unit at HRI. Minor oral and LA procedures provided within the Oral Services Unit. Inpatients treated at Bradford. Paediatric day case procedures provided within the HRI day case unit. Special Needs Dental patients are currently undertaken at CRH, cared for on ward 8C but c/o a Consultant Anaesthetist rather than a max fax Consultant
Plastics	✓	✓	All outpatient and day case activity undertaken by Bradford surgeons. Inpatients are referred to Bradford
Breast	X	✓	
Theatres and anaesthetics	✓	✓	
Radiology - MRI	✓	✓	Not routinely reported at weekends
Radiology - CT	✓	✓	Not routinely reported at weekends
Radiology - Plain film	✓	✓	Provided at Todmorden
Radiology -Fluoroscopy & DEXA	✓	✓	
Radiology - Ultrasound	✓	✓	

Service	At HRI?	At CRH?	Notes
Interventional radiology	✓	X	On call service. Joint vascular service provided with Bradford
Interventional cardiology	✓	✓	
Pathology -Microbiology	✓	✓	Extending service provision 8-8 Mon – Fri. On call service for OOH
Pathology – Histopathology	✓	✓	
Pathology – Blood sciences	✓	✓	
Pathology - Anticoagulation	✓	✓	
Pathology - Phlebotomy	✓	✓	Weekend inpatient service provided
Pharmacy dispensing (inpatients and outpatients)	✓	✓	
Pharmacy – Aseptic & Radio pharmacy	✓	✓	On call provision
Pharmacy Procurement	✓	X	
Appointments & Reception services	✓	✓	Extended hours provision of service
Health Records	✓	✓	

8.1.3 Current strengths and weaknesses at CHFT

To deliver its vision CHFT recognises the need to understand both the external strategic environment and internal strengths and weaknesses. This allows the Trust to develop a strategic response that will support not only the Trust but the wider health economy.

Like any provider organisation, CHFT has a mix of strengths and weaknesses. These include the following:

8.1.3.1 Strengths at CHFT:

- The Trust is a 24/7 acute services provider of a range of comprehensive services including Acute Medicine, Stroke, Level 2 Trauma, Paediatrics, Cardiology, Interventional Radiology, Acute and Vascular Surgery, Critical Care, and Obstetric services.
- A provider of a variety of complex interventions, for example complex Orthopaedic, General Surgical, Gynaecology, and Urology.

- With the exception of two months where Trust performance was slightly under target, CHFT performs consistently well in meeting the ED 4 hour national target of 95% with a year to date performance of 95.21%[17].
- The Trust has consistently exceeded the national target of 92% of patients being seen within 18 weeks of referral with a year to date performance of 95.8%[19].
- There has been consistent achievement of above target performance in cancer waiting times and the percentage of patients who receive first treatment within 31 days of a decision to treat.
- Hospital acquired infection (HAI) rates are low and well managed as demonstrated by year on year reductions in MRSA bacteraemia cases.

8.1.3.2 Weaknesses at CHFT:

- The Trust has an above national average rate for hospital standardised mortality ratio (HSMR) (113 vs national average of 100) and a summary hospital-level mortality indicator (SHMI)(109 vs national average of 100)
- There are significant challenges recruiting and retaining staff, particularly medical workforce, largely due to difficulties in running rotas on both sites.
- Length of stay for medical patients is variable driven in part to wider system pressures and delayed transfers of care, which are running at 4.5% year to date (above the national stretch target of 2.5%) for the whole Trust.
- The Trust continuously runs at an average of 80 patients who are medically fit for discharge but who may have other health care needs which could be accommodated through alternative out of hospital models. The number of daily discharges before 11am is 9.94% against a target of 28%[19]
- There is a chronic outlier problem driven by intra and inter site configurations.
- Of medical spells, 4.91% incur more than 2 ward movements compared to a target of 2%[19].
- There is variation in waiting times for medical treatment in the ED especially out of hours. Cancer referrals to tertiary providers was historically 32% against a target of 85%. This has improved significantly with recent performance over 70%.
- There are low level friends and family response rates and particular challenges in obtaining patient feedback in ED.

8.1.4 CQC inspections and monitoring

A routine inspection of the Trust by the Care Quality Commission (CQC) was implemented in August 2013. The CQC reported in October 2013 that the Trust met all of the required care standards with the exception of safety and suitability of premises, though this was deemed to have a minor impact on service users.

Of note, by the time of the CQC visit in August 2013, the Trust had made significant improvement with regards to an earlier concern in relation to the management of patient records, identified by

[17] November 2015 Trust Board Report

the CQC in January 2013. At this time the CQC identified that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. The Trust implemented a number of correcting actions including:

- the undertaking of significant work to raise professional standards across all health care professionals
- review and replacement of all nursing documentation
- the training of all nursing staff on completion of new documentation
- the development of a managed repository to ensure appropriate governance was in place
- the establishment of version control on all documents
- audits of documentation standards

The work to improve the management of medical records, including strengthening governance has allowed the Trust to be in a better position to implement the planned Electronic Patient Record (EPR) system.

Standards	HRI	CRH
Respecting and involving people who use services	Met this standard	Met this standard
Care and welfare of people who use services	Met this standard	Met this standard
Safety and suitability of premises	Action needed	Action needed
Assessing and monitoring the quality of service provision	Met this standard	Met this standard
Complaints	Met this standard	Met this standard
Records	Met this standard	Met this standard

Table 7: Overview of CQC inspection of CHFT in August 2013

Broadly, the CQC found that people were receiving the care they needed in the areas of the Trust they visited and that the majority of people who used the visited services provided positive feedback on their care and treatment.

A further inspection was undertaken by the CQC in February 2014 in order to assess whether the improvements required in relation to the safety and suitability of premises had been undertaken. This inspection led to the CQC being satisfied that the required improvements had been made and the Trust met the standard.

Standards	HRI	CRH
Safety and suitability of premises	Met this standard	Met this standard

Table 8: CQC re-inspection findings in February 2014

The table below describes the current CQC ratings for the Trust:

Standards	HRI	CRH
Treating people with respect and involving them in their care	Met this standard	Met this standard
Providing care, treatment and support that meets people's needs	Met this standard	Met this standard
Caring for people safely and protecting them from harm	Met this standard	Met this standard
Staffing	Met this standard	Met this standard
Quality and suitability of management	Met this standard	Met this standard

Table 9: Current CQC ratings for the HRI and CRH[18]

Intelligent Monitoring is a CQC tool built on a set of indicators for monitoring risks to the quality of care. Intelligent monitoring reports highlight those areas of care that have a high impact on service users and relate to the five key questions that are asked during inspections, namely: are services safe, effective, caring, responsive, and well-led? They are designed to assist providers in identifying areas for prioritisation.

In the most recent report, published in May 2015, the Trust was banded as a priority level 5. For context, band 1 contains trusts that are the highest priority for inspection and band 6 the lowest. The report highlighted elevated risks for the following:

- The proportion of patients assessed as achieving compliance with all 9 standards of care as measured through the hip fracture database (April 12 to March 13); and
- The Monitor governance risk rating of red (which signifies enforcement action).

Risks were reported for the following:

- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator; and
- Monitor-continuity of service rating of 2 which represents material risk

The above risks relating to compliance with all 9 standards as measured through the hip fracture database and the overall team-centred rating score for key stroke unit indicator were also highlighted in the previous CQC intelligent report from December 2014.

[18] Accessed via CQC website http://www.cqc.org.uk/location/RWY01 and http://www.cqc.org.uk/location/RWY02 (accessed 23rd December 2015)

8.1.5 Performance[19]

In recent years a set of nationally defined performance metrics have been developed. Data in these areas are collected and reported on centrally by NHS England (before April 2013 by the Department of Health), allowing for a level of comparison between Trusts to be developed. Trusts also routinely collect and report internally on this information. The following subsection provides an overview of the clinical and operational performance of the Calderdale and Huddersfield NHS Trust in August 2015 or over the period April to October 2015, in the following areas:

- Consultant referral to treatment 18 week performance
- ED four hour target
- Cancer waiting times
- National safety metrics

The data source for this performance section is the CHFT Integrated Performance Report for October 2015[19]. The Trust met the national targets in many areas, for example the Emergency Care Standard, delayed transfer of care and cancelled operations performance were above the national target for October. However, , there are key areas where the Trust did not meet the national target for October 2015, for example HSMR remaining high and readmission rates being below target.

8.1.5.1 Consultant Referral to Treatment 18 week performance:

Performance against the target of 90% of admitted patients having a referral to treatment time of less than 18 weeks is shown in Figure 16 below. Performance against the target of 95% of non-admitted patients having a referral to treatment time of less than 18 weeks is shown in Figure 19 below.

For both admitted and non-admitted pathways CHFT has performed above the national target. For admitted patients, the percentage RTT of less than 18 weeks peaked over the period in July 2015 at 92.79%, and has since declined to 90.20% in October 2015, becoming very close to the 90% target. This downward trend in the 18 week RTT pathway is another example of the operational pressures that are being felt across the Trust.

For non-admitted patients, the percentage RTT of less than 18 weeks fluctuated slightly over the period April to October 2015 between 98.23% and 98.89%. These non-admitted patients' performance results are comfortably above the 95% national target.

[19] http://www.cht.nhs.uk/fileadmin/user_upload/CONDENSED_PUBLIC_BOD_PAPERS_-_26.11.15.pdf

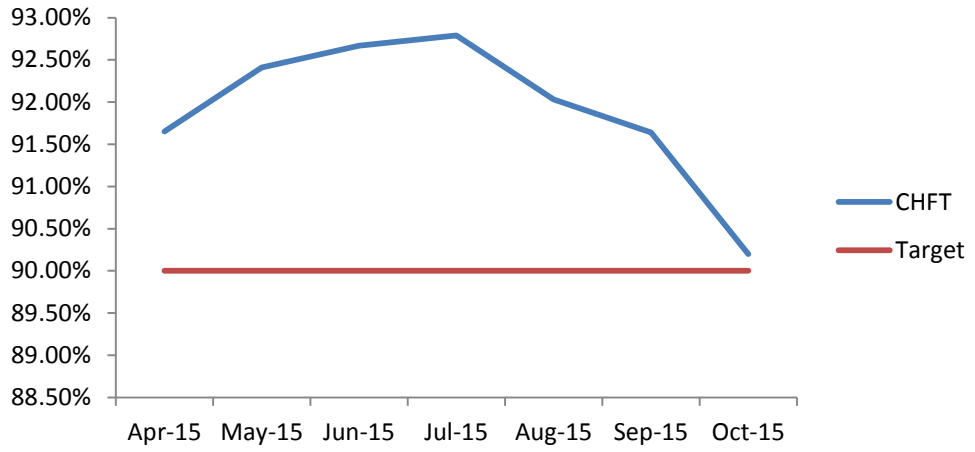


Figure 18: Performance against 18 week referral to treatment target for admitted patients, April – August 2015

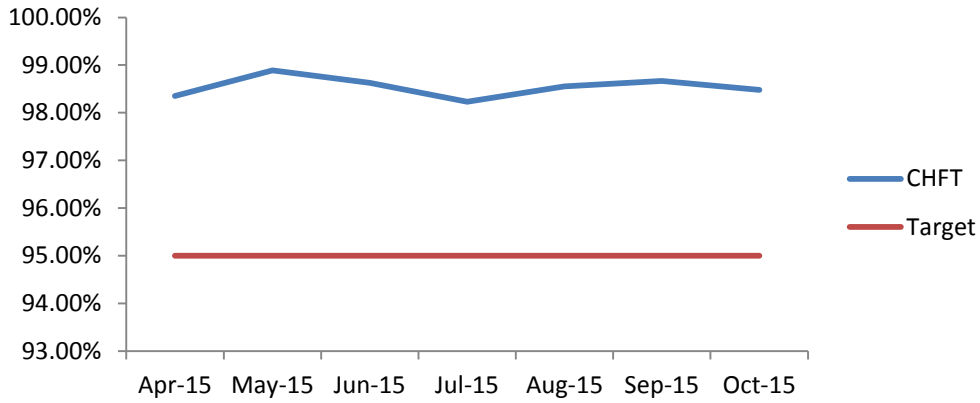


Figure 19: Performance against 18 week referral to treatment target for non-admitted patients, April-August 2015

8.1.5.2 Emergency care standard:

Overall, the Trust delivered the Emergency Care Standard with reduction in length of overall wait for those patients in the department over 4 hours. Performance against the target to treat, admit or discharge 95% of attendees at the ED is summarised in Figure 20 below. Overall, CHFT has met the target, with the exception of May 2015 where performance dipped slightly below target to 94.80%. Since July 2015 the performance has been decreasing close to the 95% target level again.

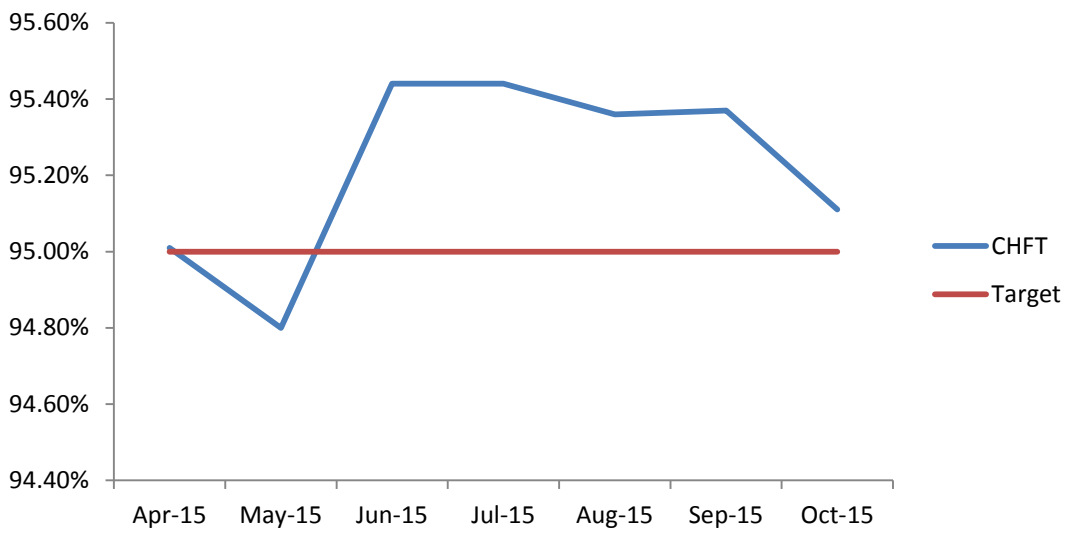


Figure 20: Percentage of ED attendees admitted, treated or discharged within four hours of arrival, April-August 2015

However, there are other Emergency Care standards where CHFT is performing at below the national target. Table 10 shows which Emergency Care performance targets that the Trust has not met in the year to date period. As well as meeting the four hour standard there has been a significant improvement in the 30-60 minute ambulance handover performance. There have been 51 breaches this business year of which over 55% were in the first month with performance sustained.

Unplanned re-attendance is also higher at the Trust than the national target (5.03% rather than 5.00%). This demonstrates that although the Trust delivered a reduction in waiting time for patients in A&E over 4 hours, there are still improvements needed to meet all Emergency Care Standards.

ED Performance Targets	National Target	Trust	Direction of travel (past 4 months)
Unplanned Re-Attendance	5.00%	5.03%	Up
A&E Ambulance 30-60 minutes	0	51	Up

Table 10: Year to date emergency performance targets that CHFT did not meet over the period April-October 2015

8.1.5.3 Cancer waiting times:

A range of nationally defined targets related to cancer treatment have been developed to ensure that patients have rapid access to diagnosis and then onward treatment, where required. Overall, national cancer standards were met at Trust level and Day 38 performance continues to improve. Performance against the target that 93% or more of suspected cancers have a first outpatient appointment within two weeks is shown in Figure 21: **Performance against two week referral to first outpatient appointment cancer target, April – October 2015.**

During the period April to October 2015 the Trust exceeded the 93% target, though with a noticeable reduction in performance from May to August. Performance against the target for referral to a specialist within two weeks for exhibited breast symptoms where cancer is not initially suspected is shown in Figure 22 below. Again, for this indicator the Trust performed above the target

level. For this indicator, there was a noticeable increase in performance from July to August followed by a decrease back to a similar level in October 2015.

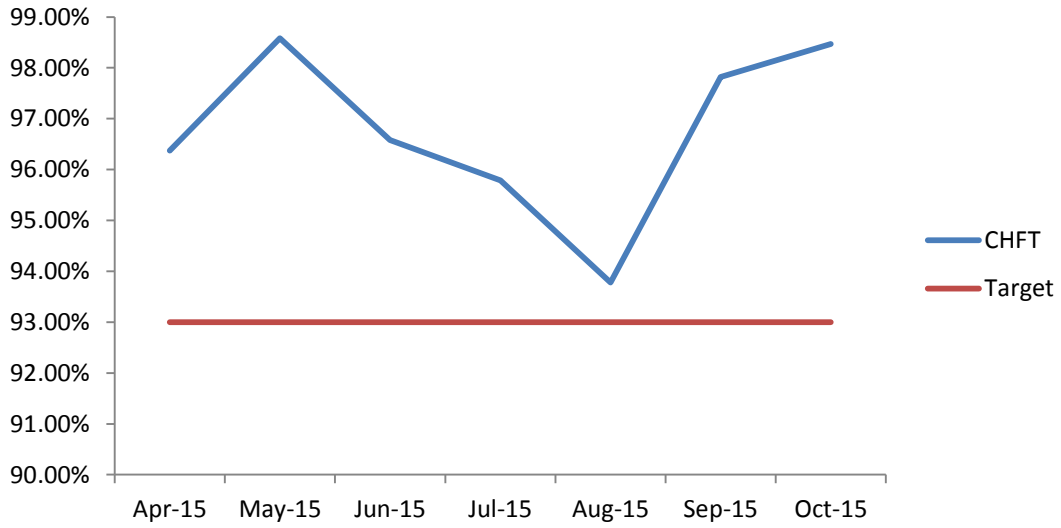


Figure 21: Performance against two week referral to first outpatient appointment cancer target, April – October 2015

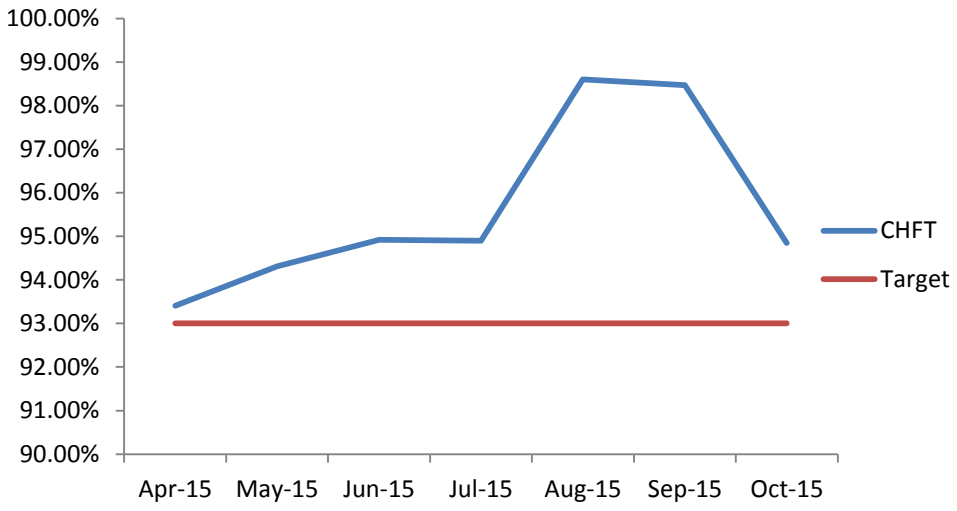


Figure 22: Performance against two week target for exhibited breast symptoms where cancer not initially suspected, April – October 2015

8.1.5.4 Infection Prevention and control

National safety metrics were devised to give an 'at a glance' view of the current performance of a Trust. The most recent performance for CHFT is shown in Table 11 below.

Metric	CHFT (year to date)	Target (year to date)
MRSA	3 cases	0 cases
Clostridium difficile	14 cases (10 unavoidable, 4 avoidable)	21 cases
Hospital Standardised Mortality Rate (1 year rolling data August 2014 to July 2015)	113.00	100.00
Local SHMI – relative risk (1 year rolling data April 2014 to March 2015)	109.1	100

Table 11: Overview of national safety metrics at CHFT

8.1.6 Management of quality

As part of its continued commitment to improving quality across the organisation, the Trust has identified the following four Quality Account priorities for FY16:

Domain	Focus/Priority
Safety	Improving Sepsis Care (aligned with CQUIN measurement)
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)
Effectiveness	Improving the discharge process
Experience	Better Food & Improving Nutrition (aligned with CQUIN measurement)

Table 12: Trust quality account priorities

These areas and others form the part of the Trust's wider quality strategy as outlined below in Figure 23.

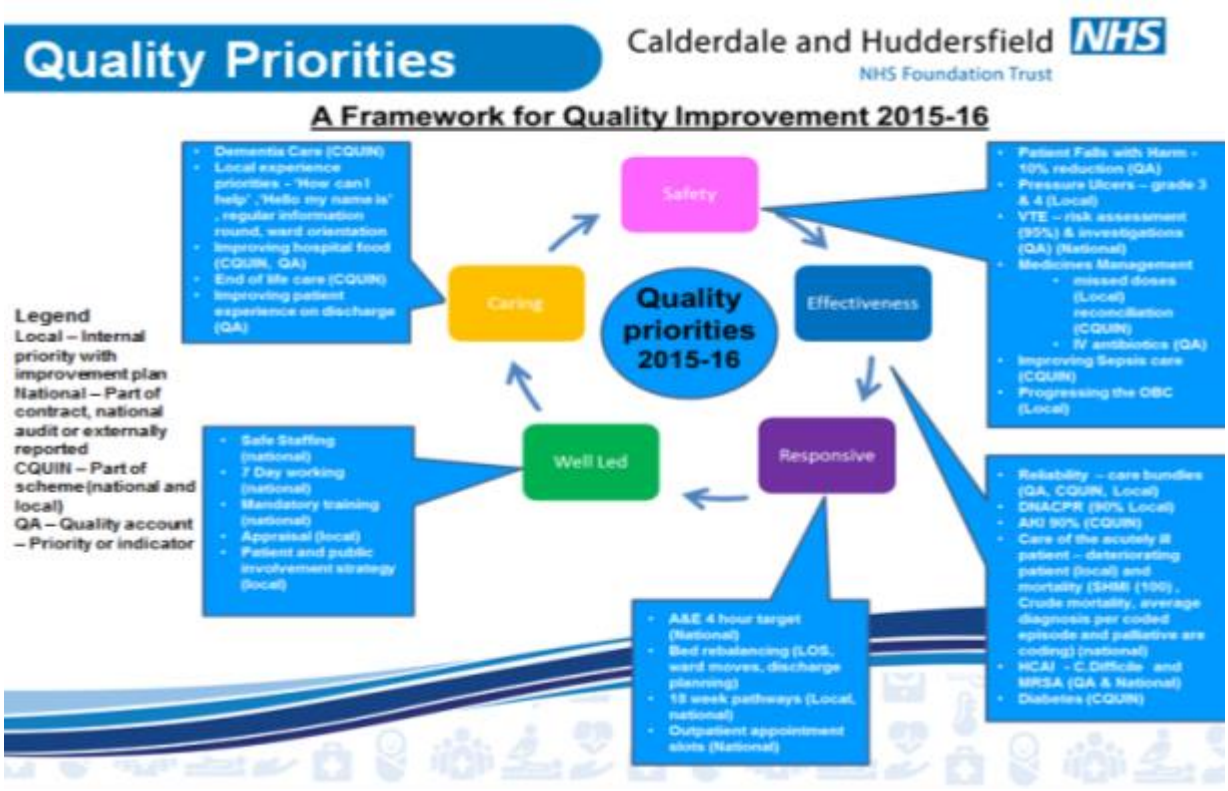


Figure 23: CHFT's quality priorities 2015-16

There are also nine CQUIN areas for FY16 as listed overleaf. The information contained in the Q2 performance box provides a quick overview of target attainment during the second quarter of the financial year, where applicable.

	Indicator Name	Target	Q2 Performance	Status
1	Acute Kidney Injury	45%	32%	
2a	Sepsis Screening	Baseline	40%	
2b	Sepsis Antibiotics	Baseline	63%	
3	Urgent care	85%	88%	
4a	Dementia - Find, Assess, Investigate and Refer	90%/90%/90%	91%/100%/100%	
4b	Dementia - Clinical Leadership	Written report	Y	
4c	Supporting Careers of people with Dementia	Written report	Y	
5a	Asthma Care Bundle	Q3=72%	80%	
5b	Pneumonia Care Bundle	Q3=70%	78%	
6	Diabetes – Inpatient	50%	64%	
7a	Medicines Reconciliation/E-Discharge	80%/70%	82%/88%	
7b	Medicines Discharge - Improvement	Development	Y	TBC
8	End of Life Care	Monitoring	44%	
9a	Nutrition patient satisfaction	70%	76%	
9b	Nutrition reduce waste	Baselining	5.48%	TBC
9c	Nutrition Vending	Written report	Y	

Table 13: CHFT CQUINs for FY16

8.1.7 Current challenges that impact on the provision of clinical services

The Trust is experiencing a number of pan-Trust challenges in ensuring continued delivery of consistent, safe, high quality care. These can broadly be divided into the following categories:

- Operational and quality
- Workforce

These challenges are set against a difficult financial environment for the Trust, the wider health economy, the NHS, and social care as a whole. The financial pressures being felt across the system are exacerbating many of the operational challenges that the Trust is facing.

8.1.7.1 Operational and quality challenges

- **Split service provision:** Some services are split across the two sites in Halifax and Huddersfield leading to a disjointed service and experience for patients. One example of this is in paediatrics. At present, paediatric medicine and surgery are not co-located on the same hospital site. This means that currently children that have urgent medical and surgical needs do not receive shared care from a consultant surgeon and a paediatrician. It also means that if an urgent consultant paediatric opinion is required out of hours, a consultant paediatrician on call for CRH may have to attend HRI whilst also being on call for acute paediatrics and neonatology at CRH.
- **Meeting Royal College recommendations / standards:** Currently the two Emergency Departments at CRH and HRI are non-compliant with many of the standards for Children and Young People in Emergency Care settings [20] with regards to having ready access to paediatric specialist trained staff. An additional challenge faced by the Trust due to the current configuration across both sites includes meeting the Royal College of Paediatrics and Child Health standard[21] of a consultant paediatrician being present and readily available in the hospital during times of peak activity, seven days a week.

  Challenges recruiting and retaining senior emergency department clinicians mean that the Trust is currently unable to meet the following College of Emergency Care (CEM) recommendation for a minimum of ten consultants per emergency department[22]:

  "With fewer than ten consultants it is difficult to sustainably provide extended cover during weekdays and weekends. Something will have to give: usually extended hours, or the health of the consultants."

  This is the position that CHFT is finding itself in at present. Currently there are 5 consultants in Halifax and 5 in Huddersfield, a distance of only 5 miles. This negatively impacts on the safety and outcomes of care that can be achieved and is not a sustainable clinical model of provision.

[20] http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf
[21] http://www.rcpch.ac.uk/improving-child-health/better-nhs-children/service-standards-and-planning/facing-future-standards-act Revision of the Standards 2015
[22] The College of Emergency Medicine, "Rules of Thumb" for Medical and Practitioner Staffing in Emergency Departments 2015

Additionally, the provision of a critical care unit at each site means that the Trust is not currently in a position to fully comply with the D16 NHS England service specification for critical care which includes reference to workforce standards

- **Patient safety:** The Trust is working hard to improve patient safety performance indicators but there is room for improvement. For example, as noted earlier in this document, the Trust reports an above average hospital standardised mortality ratio. It is believed that dual site working (that causes increased inter-hospital transfer of patients and high number of medical out-lying patients) is a causative factor.
- **Inter-hospital transfers**: Although some services are on both sites, many are confined to only one of the sites and there is therefore often a need for inter hospital transfer of patients due to a lack of co-location of all the expertise needed to manage certain conditions (i.e. trauma and acute surgery, oncology and haematology are at Huddersfield and stroke, paediatrics and complex obstetrics are at Halifax).
- **Patient experience**: At present the Trust is operating at an elective surgery cancellation rate of 0.62% for the year to date against a target of 0.60%. However, when looking at divisions specifically this rate is higher: 0.96% for the Families and Specialist Services division (which includes paediatrics, obstetrics and gynaecology) and 0.90% for the Surgical and Anaesthetics division. The reasons for this are varied including equipment failure amongst others.

8.1.7.2 Workforce challenges

Recruitment and retention of the senior medical workforce

There are a number of services which are experiencing challenges recruiting and retaining substantive senior medical workforce leading to an over-reliance on middle grade doctors and / or locums. The reliance on middle grade doctors results in less specialist input into patient care, as required in line with NHS England standards, whilst the widespread use of locums / temporary staff results in a lack of continuity of care and a negative impact on staff morale and sickness / absence rates.

Dual site running, particularly in relation to out of hours rotas, is exacerbating the reliance on junior and/or temporary staff. Examples of where this is a particularly difficult issue are acute medicine, radiology, emergency services and paediatrics.

Emergency medicine

At present the Trust is experiencing the effects of a national shortage of emergency doctors at both consultant and middle grade levels. This means that the current consultant pool is stretched through covering vacancies which the Trust is unable to recruit to. As a result, the two emergency departments are heavily reliant on cover from locum middle grade doctors to ensure care remains safe. However, the Trust risk register documents the risk of poor clinical decision making due to the dependence on locum middle grade doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints. Double running of emergency medical services leads to very thinly spread middle grade cover particularly out of hours and nights. It is also

difficult to flex other staff including nursing and allied health professional staff across two emergency sites and critical care units.

The number of consultants across both sites is below establishment. There is a gap of 3 consultants with 9 being in post compared to an establishment of 12 (FY17 plan). This leaves the service heavily reliant on locum cover, however despite this there is still insufficient locum cover to cover the consultant gap.

There have been particular difficulties recruiting to middle grade posts in ED leading to a workforce gap of 6 WTE posts against an establishment of 10. Of the 4 in post, 3 are unable to work nights due to occupational health issues leading to reliance on locum staff for service provision at night

In recent months the Trust has experienced the resignation of Consultant grade staff in Emergency Medicine and other Medical specialities and the reasons given by individuals has been the current configuration of services across two sites. The Trust's high level of concern regarding the sustainability of delivering ED services on two sites has resulted in the Trust developing a contingency plan should there be an urgent need on the grounds of safety to temporarily close one of the ED sites. This plan has been shared with local CCGs, overview and scrutiny committees and Monitor.

Medical specialties

Pressures are also being felt amongst the wider medical consultant workforce. As a result of vacancies and challenges with recruiting and retaining staff, the Trust is unable to deliver specialty-specific rotas. This means that specialist consultants are left covering general medical on calls. The current on call rotas for medical consultants is 1:5 which hinders recruitment and retention of the medical workforce further exacerbating challenges with operational delivery.

The Trust is not currently able to substantively recruit to meet the rotas of the two sites. A number of recruitment processes have failed due to lack of applicants. The turnover of medical staff in the Trust is increasing with Consultant staff exiting the Trust and giving reasons that their decision is due to the current configuration of Trust services across two sites and that this compromises the quality of care that can be provided and impacts on workload and frequency of on-call responsibilities.

Radiology

The radiology service is experiencing a workforce gap of 4 consultants against an establishment of 17 consultants i.e. 24% of consultant posts are vacant. The Trust has tried and failed to recruit, resulting in a service which is being stretched beyond capacity to meet the growing demand for diagnostics across both sites. In order to ensure that patient quality does not suffer, the Trust is incurring a significant cost pressure through outsourcing some of its radiology work to the private sector.

8.1.8 Developing the future model of care for hospital services

There is a common understanding across the local health economy that a new model of care to enable people who do not need hospital services to receive care closer to their own homes and communities is required. This is not withstanding the need to address the following priorities:

- Ensure that services are safe, high quality and affordable for the future

- Ensure that all providers (acute healthcare and otherwise) are meeting best practice standards and guidelines to improve patient experience and outcome
- Minimise the variable care received by those people who need hospital services

As part of a whole system approach, the Clinical Model underpinning the future model of care for hospital services in Calderdale and Greater Huddersfield was developed as a result of collaboration between commissioners and other key local health economy stakeholders to ensure that health and social care services are fit for the future. The model builds on the work undertaken by commissioners to strengthen and enhance community services as part of their care closer to home programmes.

The Clinical Consensus Model outlining the future provision of hospital care is the result of collaboration between clinicians from primary and secondary care, specifically from both Calderdale and Greater Huddersfield CCGs and the Trust.

Development of the model has been a result of joint work through five clinical workshops and four clinical design groups (covering Planned Care; Urgent Care; and Maternity and Paediatrics), working to a joint Hospital Service Programme Board. The clinical design groups have met five times in total over a period of ten months between November, 2014 and August 2015. Additional support has been provided by individual discussions between Clinicians from the CCGs and CHFT and by CCG discussions in their clinical development forums.

The outputs of the model development workshops included:

- Development of a common understanding of the commissioners' journey and definitions for unplanned and planned care
- Agreement of the scope for hospital services, the standards and outcomes expected by commissioners
- Development of a common set of assumptions about the optimum configuration of the future model for Hospital Services
- Agreement on which elements of specialised provision could be undertaken locally
- Consideration of CHFT's position in respect of quality and finance and the changing national picture

The stakeholders involved in model development identified nine key principles regarding the future potential Clinical Model design, namely:

- Deliver care locally and retain services close to home and, where possible, also bring additional services closer to home;
- Deliver services in accordance with best practice standards in relation to standards of Care and Patient Experience;
- Provide better/improved access to primary care services;
- Build resilient, sustainable services, users and communities;
- Provide a financially sustainable system;
- Are underpinned by high levels of performance and delivering World Class outcomes;
- Are planned and delivered in a joined up / integrated way across agencies;

- Maximise the use of technology to support local delivery, effective decision making and cross location working; and
- Are supported by a sustainable workforce with the right leadership, skills, values and behaviours optimising professionals working at their skill level.

Clinical consensus across clinicians from primary and secondary care, signed off by the CCG Clinical Chairs and CHFT's Medical Director, on all areas of the model was reached on 19th October 2015.

In total the Clinical Consensus model underpinning the future model of care for hospital services was a result of a total of 284 hours of clinical input from conception to finalisation – this demonstrates a significant level of clinical buy-in and provides assurance that the model consists of clinical adjacencies which will optimise the quality of patient care.

The key principles underpinning the Clinical Consensus Model[23] are summarised below:

Table 14: Key principles of the Clinical Consensus Model

Priority	Key principle	How the potential model achieves the key principle
Urgent care	Provide a highly responsive service for those people with Urgent care needs that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.	• Care for the smaller number of patients with 'once in a lifetime' life threatening illnesses and injuries will be provided in a single emergency centre or a specialist emergency centre with the very best expertise and facilities in order to maximise the chances of survival and a good recovery. • There will be two (or potentially three) Urgent Care centres (UCCs): Huddersfield Royal Infirmary, Calderdale Royal Hospital and (potentially) one other location. Within these UCCs, services will be provided to suitable "walk-in" patients with minor illness and/or injury including GP Out of Hours service. The centres will be medically-led by a clinician with the knowledge and skills to undertake triage and autonomous decision making regarding the next steps in an individual's care. • Patients with life-threatening illness and injury will be taken by ambulance directly to the Emergency Care Centre or Specialist Emergency Care Centre.
Emergency	Care for the smaller	• Emergency care will be provided by a single

[23] Aligned to the 'Future Hospital: Caring for Medical Patients' report (September 2013)

Priority	Key principle	How the potential model achieves the key principle
care	number of patients with Emergency Care needs in a single emergency centre or a specialist emergency centre with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.	unified Emergency Care centre which would provide emergency services, unplanned care medicine and ED services for Calderdale and Greater Huddersfield • Specialist Emergency Care will continue to be provided as in the current model, where certain specialisms such as severe trauma are provided at the Specialist Emergency Care centre on a West Yorkshire basis. This Specialist Emergency Care centre will have the best expertise and facilities to deal with these specialist cases, in line with the key principle.
Planned care	For those elements of Planned Care where Hospital facilities are required, deliver that care as part of a broader integrated system, working across services, to keep people healthy and improve health at a population level.	• Planned care will be provided in the hospital only when it cannot be delivered elsewhere and also delivering that care as part of a broader integrated system, for example through a new approach to Outpatient care. • There will be a new approach to Outpatient care providing better offers to patients, in community wherever possible, and focusing on a significant reduction in out-patient follow-ups. • The new Clinical Model will continue the work to move appropriate elective activity to day cases, and to move appropriate day case activity to out-patient procedures – in line with the evidence base and with specifications for services that would support the new model, e.g. District Nursing. • There will be co-location of services on only one site where there is a clinical need due to the interrelationships with other clinical services.
Maternity	Deliver Maternity care	• The proposed new Clinical Model is

Priority	Key principle	How the potential model achieves the key principle
services	that is integrated with specialist services and provides choice for mothers.	designed to meet key principle of integrated maternity services by reflecting the critical interdependencies between Paediatric and Maternity services, Emergency Care and Urgent Care, and Community Care. There will be an emphasis on provision of community care wherever possible. • The proposed model will include extended ante-natal, intra partum and post-natal care provided in the community where possible. • There will also be choice in relation to where the birth takes place and midwifery led maternity on both hospital sites. • Consultant led Obstetrics and Neo-natal care will be co- located with the Emergency Care centre.
Paediatric services	Deliver Paediatric care that is integrated with specialist services and provides effective transition for children to adult services.	• The new Clinical Model for Paediatric care will include enhanced community Paediatric services including hot clinics to support GPs in-hours. • Paediatric Surgery and acute care inpatient medical care will be co-located within the Emergency Care Centre. • All children aged 5 years or under will be seen at the ED (not in the UCC) even if they have a minor illness or injury • Children aged over 5 years with a minor injury will be seen in the UCC • All children with an illness that requires hospital attendance will be seen at the ED

8.1.9 Benefits to be realised from the proposed future model of care for hospital services

There is evidence to support the proposed outline model of care for hospitals including:

- **Local evidence of better outcomes from service co-location**
  - In FY06 a partial reconfiguration of some hospital services was implemented to centralise acute surgery and trauma at HRI. Data published by Dr Foster shows that since FY06 to FY13 there has been a significant reduction in surgery and trauma service mortality rates (General Surgery mortality has reduced from 97 to 64, and Trauma and Orthopaedics mortality has reduced from 90 to 53). A full reconfiguration of all the acute specialities and emergency services on a single hospital site has the potential to enable even greater benefit from similar improvements in safety and reductions in mortality.
- **Evidence of better outcomes from increased senior clinical decision making**
  - A King's Fund report on hospital reconfiguration[24] states that "There is strong evidence about the importance of senior medical and other senior clinical input to care, particularly for high-risk patients." In addition, "There is strong evidence to support a senior doctor presence in A&E seven days a week." The proposed model of care will directly enable increased senior medical and clinical input to care, including in the Emergency Department.
- **Evidence of better outcomes from surgery reconfiguration**
  - There is evidence that the co-location of emergency and acute medical and surgical expertise can enable significant improvements in survival and recovery outcomes despite an initial increased travel time to the ED department. For example the recent national reorganisation of major trauma services which reduced the number of sites showed a 20% increase in survival despite increased travel time. Similar results have been reported for cardiac and stroke patients.
  - The co-location of acute specialty teams on a single site could prevent potential safety events and delays in care, which are a risk in the current configuration, where medical patients are frequently transferred between the two sites

There is no degradation of any existing services anticipated as a result of the proposed model. Some services may experience a change in the location at which the service is delivered. However, there is anticipated to be significant associated improvements in quality as a result of the implementation of the model, particularly through the consolidation of all acute services onto the unplanned care site.

[24] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

Table 15 provides an indication of whether the services below will be impacted by the reconfiguration i.e. where there will be a change in service scope from current.

Services	Impact?		
	Yes	No	Comments
Anaesthetics and Theatres		✓	Theatres will be available on both sites. The unplanned care site theatres will be used for emergency / non-elective work with little day case and elective activity. The planned care site will be exclusively for elective (including day case) activity
Cardiology	✓		Service centralised onto the unplanned care site
Critical Care	✓		Expansion of the critical care unit onto the unplanned care site only
Dermatology		✓	
Diabetes		✓	
Elderly Care	✓		Service centralised onto the unplanned care site
Emergency (excluding urgent care)	✓		There will be a single ED on the unplanned care site
Endoscopy		✓	Endoscopy will continue to provide a service on both sites with the acute service centralised on the unplanned care site
ENT and audiology		✓	
Gastroenterology	✓		Service centralised onto the unplanned care site
Gynaecology		✓	
Haematology		✓	
Maternity Midwifery		✓	Midwife-led birthing units will continue to be available on both sites
Maxillofacial		✓	
Oncology		✓	
Ophthalmology		✓	
Paediatrics	✓		Inpatient paediatrics services (medicine and surgery) centralised on the unplanned care site
Pain		✓	
Plastics		✓	
Respiratory	✓		Service centralised onto the unplanned care site
Rheumatology		✓	
Stroke		✓	
Trauma and Orthopaedics		✓	Unplanned surgery on unplanned care site, majority of planned surgery on planned care site
Urgent care	✓		The single ED located on the unplanned care site will be supported by urgent care centres co-located at both the unplanned and planned care sites (and may be supplemented by another one in the community), in order to provide treatment for suitable patients with minor injuries and illnesses
Urology		✓	All surgery on unplanned care site
Vascular Surgery		✓	All surgery on unplanned care site

Table 15: The high level impact of reconfiguration on each service

Strategic benefits arising from the proposed model of care for hospital services are summarised in Figure 24 below. The benefits have been arranged to demonstrate that the proposed model of care for hospital services meets the strategic objectives of patients, Health & Wellbeing Boards, their commissioners and the Trust.

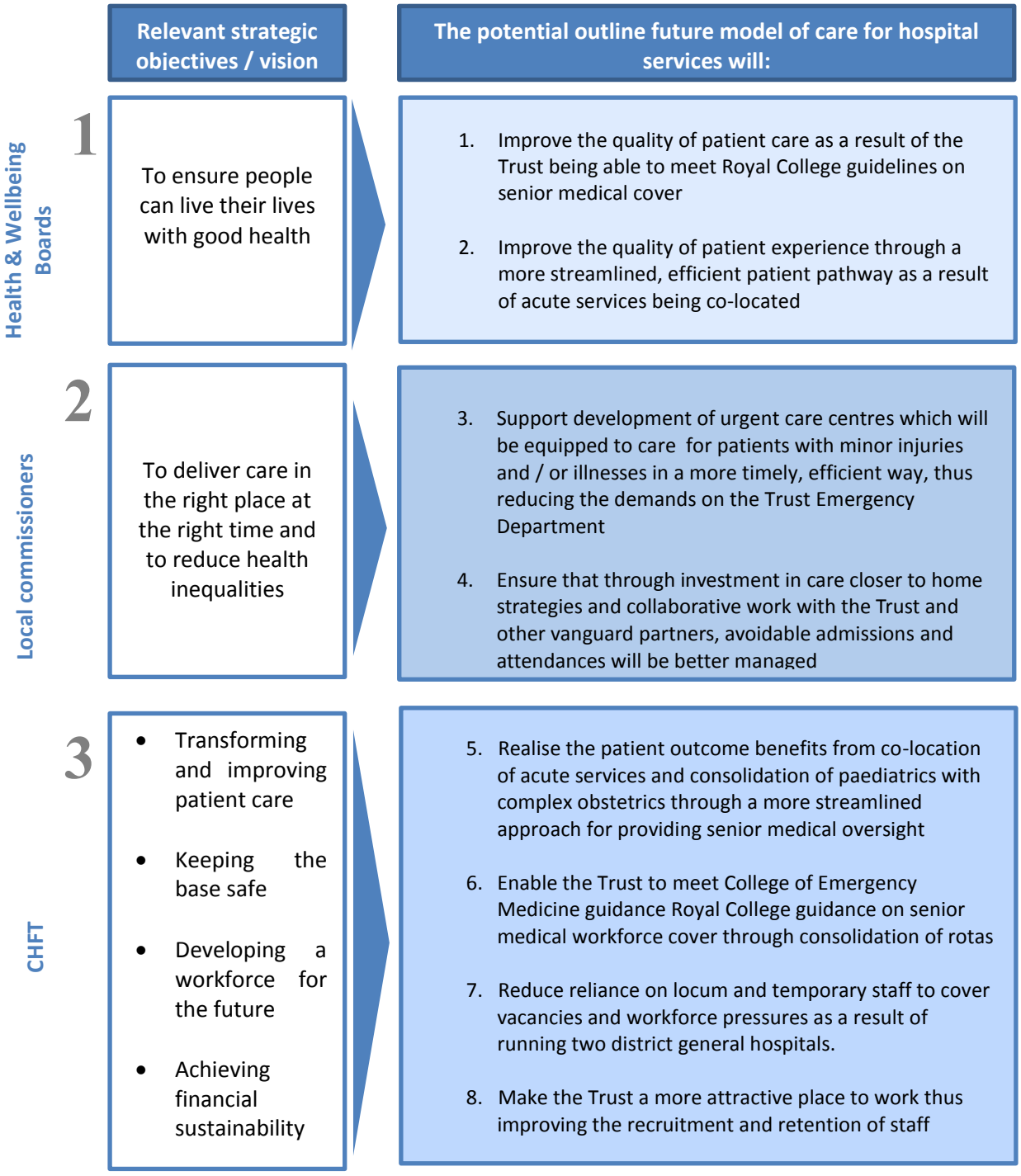


Figure 24: Alignment with local health economy strategic objectives

The proposed Clinical Model will enable the Trust, in particular, to better respond to the challenges it is facing in the following ways:

- **Split service provision:** Ensuring that paediatric medicine and surgery are located on one site would ensure that paediatric consultants can have oversight of and input to both specialties thus facilitating the provision of shared senior paediatric and surgical care for patients. This would enable the delivery of more streamlined care for patients and ensure a more efficient use of paediatric workforce.

  Additionally, co-location of paediatrics with the paediatrics Emergency Department will allow for paediatric emergency medicine (PEM) trained staff to work alongside and support unplanned care paediatrics which is experiencing medical staff shortages.

- **Meeting Royal College recommendations / clinical standards:** Co-location of paediatrics with paediatrics emergency care will support conformity with the standards for Children and Young people in Emergency Care settings. Furthermore, the co-location of paediatric medicine and surgery would ensure that the Trust is better able to conform to the Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years

  A single point of access for critical care beds will result in the Trust being better able to respond to the D16 critical care workforce standards thus supporting the delivery of improved patient outcomes for critical care and complex patients.

- **Patient safety:** Avoiding the need to spread the senior medical workforce thinly across two sites will ensure that the Trust has a more substantial approach to reducing its above national average hospital mortality ratios.

- **Inter-hospital transfers:** The reconfiguration of acute medicine onto one site, to support the activity of the single ED, would have the advantage of reducing inter-hospital transfers which currently take place frequently for acute medical admissions, when one or other site has reached its maximum medical bed capacity. Eliminating transfers of medical patients will improve safety, optimise patient flow in ED, shorten waits to definitive care, reduce ED breaches of the four-hour target, and reduce the workload on the ambulance service which is currently responsible for providing these transfers.

- **Patient experience:** Providing planned services, including surgery, in a dedicated site that supports access to treatment, surgery or therapy input minimising the risk of disruption from emergency cases.

- **Medical workforce / senior medical cover:** The changes in service and workforce model through consolidation into a single emergency department will ensure that the Trust will be in a position to meet the College of Emergency Medicine recommendation for a minimum of 10 Consultants in Emergency Medicine per emergency department and ensure compliance with patient to staffing ratios. This will improve the likelihood of survival and a good recovery for patients.

  A single emergency department, and separation into unplanned and planned services, will enable the Trust to leverage its workforce more efficiently and leave the Trust in a better

position to meet standards around 7-day working in the future and the realisation of specialty rotas.

The co-location of acute services will yield a reduction in rota frequency and intensity due to not having to cover two sites. In turn this will reduce workload pressures on staff and improve the resilience of services in areas such as acute medicine, critical care, paediatrics and radiology.

Under the proposed Clinical Model, it is anticipated that the majority of radiologists will work from the unplanned care site and report on the planned care site remotely. This would enable the merging of the current two site-based rotas into one, improving the resilience of the service and the attractiveness of the post to potential new recruits. Additionally, there may be no need for an on-call CT radiographer service on the planned care site, which would alleviate some of the pressure of competition from private providers for this workforce group.

Trust-wide benefits are underpinned by a range of specialty-level benefits. These are realised through service developments and through changing the model of care to support the clinical adjacencies that are the basis of the proposed Clinical Model. The resulting service changes are anticipated to deliver significant benefits to the local population, as well as to the local commissioners and staff working within the reconfigured Trust. Benefits arising from service changes are detailed in Table 16.

Division / Directorate	Current model / problems	Proposed Model	Benefits
Medicine - Emergency Department	It is difficult to recruit sufficient numbers and seniority of staff to provide full senior medical oversight across both emergency departments. The two sites do not provide the same breadth of acute services and there is often a need for inter hospital transfer of patients as there is not a co-location of all the expertise needed on both sites	• A single unified Emergency Care centre for providing Emergency/Acute medicine and Accident and Emergency services will be located at the unplanned care site. This will include access to MAU, SAU and ITU • Access to paediatric emergency care will also be provided at the unplanned care site • There will be urgent care centres (UCC) at each hospital and potentially in one further location for the treatment of adults with minor illnesses and minor injuries • Any child aged 5 years or younger will be referred to the Paediatric Emergency Department. Children between the ages of 5-16 with minor injuries can be seen at one of the UCCs	• **Patients:** Improved patient safety and quality of care due to the shift to an operationally sustainable model and ability to provide longer periods of on-site consultant cover • **Patients:** Patients seen at appropriate site based on acuity with access to a wider range of services for patients requiring more complex care • **Staff:** A single ED will ensure that the workforce will not be stretched across two departments as is the case currently. The changes in service and workforce model will enable the College of Emergency Medicine recommendation of a minimum of 10 consultants in Emergency Medicine per ED to be achieved Recruitment and retention will improve as at present it is difficult to attract staff due to the 2 site model and frequency of on call shifts • **Patients:** Access to a wider range of services for patients requiring more complex care

Medicine - Acute Medical Directorate	Acute medical services are currently provided at both sites. Due to the clinical adjacencies required, if there is a single ED on the unplanned care site then all acute medical services will need to be located Due to difficulties recruiting and retaining sufficient numbers of senior medical staff, the Trust is unable to deliver specialty rotas at present meaning patients do not always have immediate access to the level of specialist care they may require	• Acute medical services (cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care) will be provided at the unplanned care site • The following services will integrate with ED: acute medicine, acute elderly + frailty, Comprehensive Geriatric Assessment, respiratory care, stroke and community hub (e.g. crisis intervention, RAID) • Medical cover out of hours will still be required on the planned care site • Patients will be supported with early care plans so that people that do not need acute hospital care are able to return to their usual place of residence without delay • Enhanced level of ambulatory assessment and treatment with focus on keeping people at home • Early rehabilitation will be available on the unplanned care site • Diabetes and endocrinology can be principally delivered in the community	• **Patients:** Access to a wider range of services for patients requiring more complex care • **Patients:** There will be reduction in the need for intra and inter-hospital transfers for people who have more than one clinical need • **Staff / Trust:** The reconfigured organisation will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation. Fewer Consultant vacancies will mean better continuity of care for patients. • **Patients:** Improving quality of care by providing comprehensive geriatric care for Elderly Care patients

Medicine - Integrated Specialty		• Acute oncology and haematology services will be located on the unplanned care site • Dermatology will be principally delivered in an outpatient and community clinic setting • Rheumatology will be principally based on the planned care site as most services are delivered in a day case / clinic setting • Neurology will be predominantly outpatient based • Palliative care will be principally delivered in the community	• **Patients:** Urgent access for patients with long term conditions and routine planned care will be easier and faster • **Patients:** Patients seen at appropriate site based on acuity

Surgery & Anaesthetics - Trauma & Orthopaedic Services		No change •Acute trauma will continue to be located on the unplanned care site •Unplanned orthopaedic surgery will continue to be undertaken at the unplanned care site • Planned surgery to take place on the planned care site routinely - transfers to critical care to take place if required and patients would only stay on the unplanned care site for the duration of their acute/ critical care stay before transferring back to the planned care site • High risk patients would be identified at pre-assessment for treatment on the unplanned care site Patients who are treated on the unplanned care site and who have a lengthy LOS may be transferred to the planned care site once clinically appropriate.• There is already a split of elective and non- elective activity (majority of acute work takes place at HRI, majority of elective work is at CRH) • Majority of day case work to take place on the planned care site	• **Patients:** Continued improvement in safety and mortality rates, already demonstrated by a partial reconfiguration of acute surgery onto HRI in 2005/6 • **Staff:** Consolidating non-electives and electives on single sites will ensure that rotas can be strengthened, staff will not be spread thinly and there will be less of a dependence on locums • **Patients:** There will be a greater opportunity to review and redesign patient pathways thus improving patient outcomes and the patient experience • **Staff:** Centralising the 'unplanned' work will ensure that there is greater flex in the team and a better place to work therefore improving recruitment and retention

Surgery & Anaesthetics - Operating Services, Theatres, Anaesthetics, Critical Care and Pain	The provision of a critical care unit at each site means that the Trust is not currently in a position to fully comply with D16 guidance on critical care workforce standards.	• Critical Care to be based on the unplanned care site (currently Trust does not separate ITU and HDU, beds can be upgraded or downgraded as necessary) • Patients requiring critical care will be transferred from planned care site or identified in advance at the pre-assessment stage • Full day case theatre suite needed at planned care site including recovery beds / trolleys • Pain services will be centralised at the planned care site • Endoscopy services will be available on both sites	• **Patients:** Improvement in safety and patient outcomes when critical care workforce standards are met
Surgery & Anaesthetics - General Specialist Surgical Services		• No change Acute surgery will continue to be carried out on the unplanned care site • Most inpatient planned surgery to be undertaken on the planned care site • All vascular and urology surgery (including day case) to be undertaken on the unplanned care site • Planned endoscopy will be available on both sites with acute endoscopy provided on the unplanned care site	• **Staff:** Reconfiguration will improve resilience within the staff rota due to separation of planned and unplanned surgery • **Patients:** Better patient outcomes as more complex procedures will be centralised

Surgery & Anaesthetics- Head & Neck		• All ENT surgery (elective and non-elective) to be centralised onto the unplanned care site (N.B. alternatively day cases could be undertaken on the planned care site with the exception of paediatrics) • Ophthalmology to be undertaken on the planned care site • Max fax day unit to be moved to the planned care site	

Families & Specialist services - Children's Services	Paediatrics is split between the two sites – paediatric medicine at CRH and most paediatric surgery at HRI. This means that there is sub-optimal paediatric senior medical doctor oversight at HRI. At present consultants have little time to cover HRI but there is already a single consultant on call rota at present.	• Specialist paediatric services will be co-located with the Emergency Care Centre - this will cover neonates, paediatric surgery and paediatric medicine • Neonates will be co-located with Consultant led Maternity care. • All paediatric surgery (including day case) and paediatric medical care to be co-located at the unplanned care site	• **Patients:** Co-locating neonates with all acute paediatrics and obstetrics / gynaecology will mitigate against any possible risks from having these separate at present • **Staff:** Co-location of paediatric medicine and surgery will ensure that consultants can have oversight of both. The current model of having them separate is safe but not optimal. • **Staff:** Co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially medical staffing • **Trust:** Better conformity with the standards for Children and Young people in Emergency Care settings and Royal College of Paediatrics and Child Health (RCPCH) guidance to provide consultant delivered care at peak times within the next 5 years

Families & Specialist Support Services - Women's Services		• Consultant - led obstetrics and neonatal care(currently at CRH) to be co-located on the unplanned care site • Midwife - led maternity will be available on both hospital sites • Acute and inpatient gynaecology services will be provided at the unplanned care site	• **Patients:** Patients can access a wider range of maternity care closer to home • **Patients:** Improved safety by ensuring only appropriate patients are cared for by the MLU and patients that may require obstetric care are seen at the specialist centre • **Patients:** Patients with complex obstetrics will be cared for in the centre where other specialist services (ITU/ Surgery/ Interventional radiology) are available • **Patients:** There will be 24 hour consultant cover of the labour ward and 24/7 access to a competent supervising anaesthetist • **Staff / Trust:** The Trust will be a more attractive proposition to potential recruits, with a greater level of stability, more sustainable rotas, and the opportunity for sub-specialisation

Community Services	The Trust faces a key capacity issue over the next 10 years due to a growth in demand for hospital services from the increasing population.	• The focus for rehabilitation will be outside of both sites either in community facilities or preferable in patients' own homes. Where patients require a lengthy LOS and, if clinically appropriate, they will be transferred and cared for on the planned care site.	• **Patients:** The provision of rehabilitation and reablement provision on the unplanned care site will ensure that rehabilitation can begin as early as appropriate in the patient's journey. This will facilitate quicker and more assured discharge back to the patient's own home or into the community

Table 16: Directorate-level service changes as a result of reconfiguration and the benefits associated

8.1.10 Impact of the Clinical Model on activity

An assessment of the impact of the Clinical Model on future activity, based on the proposed service and patient flow changes, has been completed. This modelling was run separately for the two main site options:

- CRH being the unplanned care site and HRI being the planned care site
- HRI being the unplanned care site and CRH being the planned care site

Additionally, a number of key assumptions were included as outlined in the following section.

8.1.10.1 Key assumptions

Key overarching assumptions that were applied to the model were:

- All modelling has been based on the forecast activity for FY16 (as at month 6)
- Growth has been modelled in accordance with the Trust financial assumptions
- The bed baseline has been adjusted to match the Trust's FY17 plan
- All movements will occur in year 5 on the basis that reconfiguration will require consultation and a capital build
- Patients not appropriate to be seen at the UCC are diverted to the next nearest ECC department based on travel time
- Walk-ins are assumed to continue to attend the emergency department they currently attend
- Patients attending the UCC that require admission or more acute treatment are transferred to the ECC
- Inpatient spells arising from an ECC attendances will move with the ECC attendances
- An additional 30 winter pressure beds have been included to provide resilience to manage seasonality variations. This is in line with the seasonal swing identified by the Medicine division.
- Significant delivery of commissioner QIPP will be realised (resulting in a 6% reduction in non-elective medical admissions per annum)
- Length of stay (LOS) reductions as follows:
  - Medicine: 6% LOS reduction
  - Surgery: Bring average LOS for non-complex hips and knees to 4 days
  - FSS: 10% reduction in paediatrics, 5% reduction in gynaecology
- Bed occupancy to be applied as follows:
  - Medicine: 90%
  - Surgery: Utilise current occupancy level – 86.4%
  - FSS: 60% for paediatrics and maternity, 90% for gynaecology

- Current average theatre utilisation (i.e. reflecting current usage of theatres) and a move to 4 hours sessions
- Expansion of ambulatory care pathways
- Reconfiguration is anticipated to have a modest, but material, impact on neighbouring providers
    - If HRI is the unplanned care site there could be an estimated 1,129 additional attendances annually at The Royal Oldham Hospital, with an incremental capacity requirement equivalent to 10 beds.
    - If CRH is chosen as the unplanned care site there could be an estimated 1,089 additional attendances at Pinderfields General Hospital, with an incremental capacity requirement equivalent to 8 beds.
- No growth in elective market share
- 3% increase in home births
- 18 critical care beds in total (an increase of 6 beds from current provision)

Key service by service assumptions applied to the model were:

Table 17: Service-level modelling assumptions

Service	Assumptions
Emergency Department	► Planned care site no longer to have an ECC, but to become an Urgent Care Centre ► All ambulances diverted to other ECCs ► Adult walk-ins matching the Trust minor injuries and minor illness UCC criteria to remain at the planned care site(if attending there) ► 5-16 year olds with minor injuries matching the Trust UCC criteria to remain at the planned care site (if attending there) ► All under 5s to divert to nearest paediatric ECC ► Increase in ED activity due to potential Dewsbury service changes (Trust estimate of 7 ED attendances per week with 38% conversion) ► UCCs will likely be GP-led
Acute Medicine	► All cardiology, respiratory, gastroenterology, acute stroke, elderly complex care and orthogeriatric care to move to the unplanned care site
Medicine – Integrated Speciality	► Rheumatology and dermatology to move to the planned care site. Nephrology to move to the unplanned care site (Leeds service) (N.B: alternatively nephrology could be based on the planned care site with consultants providing in-reach to both the unplanned care site and the community)
Surgery – General Specialist	► All urology (elective, non-elective and day case) on the unplanned care site ► All inpatient vascular surgery (elective and non-elective) on the

Surgical Services	unplanned care site ► All GI bleeds on the unplanned care site ► Increase in day cases (defined based on review of current 1 day LOS list) ► Shift all T&O, general surgical and urology inpatients from the unplanned care site to the planned care site if they have a LOS greater than 10 days (in practice will only be undertaken if clinically appropriate) ► Shift all vascular inpatients from the unplanned care site to the planned care site if they have a LOS greater than 14 days (in practice will only be undertaken if clinically appropriate)
Surgery – Trauma and Orthopaedics	► All emergency and non-elective trauma and orthopaedics to be on the unplanned care site ► Elective orthopaedics (with the exception of hip revisions/ other complex patients) to be on the planned care site ► 90% of hand trauma on the planned care site (to be developed further)
Surgery – Head & Neck	► All ENT emergency, elective and non-elective inpatient work to be moved to the unplanned care site ► All maxillo-facial and ophthalmology work to be moved to the planned care site
Surgery – Operating Services, Theatres, Anaesthetics, Critical Care and Pain	► Critical Care to be based on the unplanned care site ► Patients requiring critical care will be transferred from the planned care site or identified in advance at the pre-assessment stage
Paediatrics	► All paediatric medicine and surgery at the unplanned care site
Gynaecology	► All gynaecology at the unplanned care site (with the exception of day case hysteroscopies which may take place at the planned care site) ► Midwife-led units on unplanned care and planned care sites ► All consultant led obstetric activity at the unplanned care site

8.1.11 Modelling outputs

The modelling was designed to provide the following outputs:

- Bed capacity requirements
- Number of theatre sessions required in order to inform theatre requirements
- The number of consultant vs midwife-led births at each site

- Breakdown of ECC vs UCC attendances (based on the minor injuries/ minor illnesses criteria)
- Prediction of the impact on other providers

The above outputs were utilised to prepare the cost model which identifies the total cost (revenue, capital, requirements and income) for each of the site options referred to earlier in this document.

8.1.11.1 Bed capacity requirements

At present, there are over 400 beds located at each site. Modelling indicates that the Trust would require a total bed base of 732 beds if CRH was the unplanned care site. However, if HRI were to become the unplanned care site there would be a requirement for 734 beds, the net 2 bed difference between the two scenarios being due to a small difference in activity going to other providers. Figure 26 starts from the agreed average bed base included in the Trust's FY 17 plan (811).

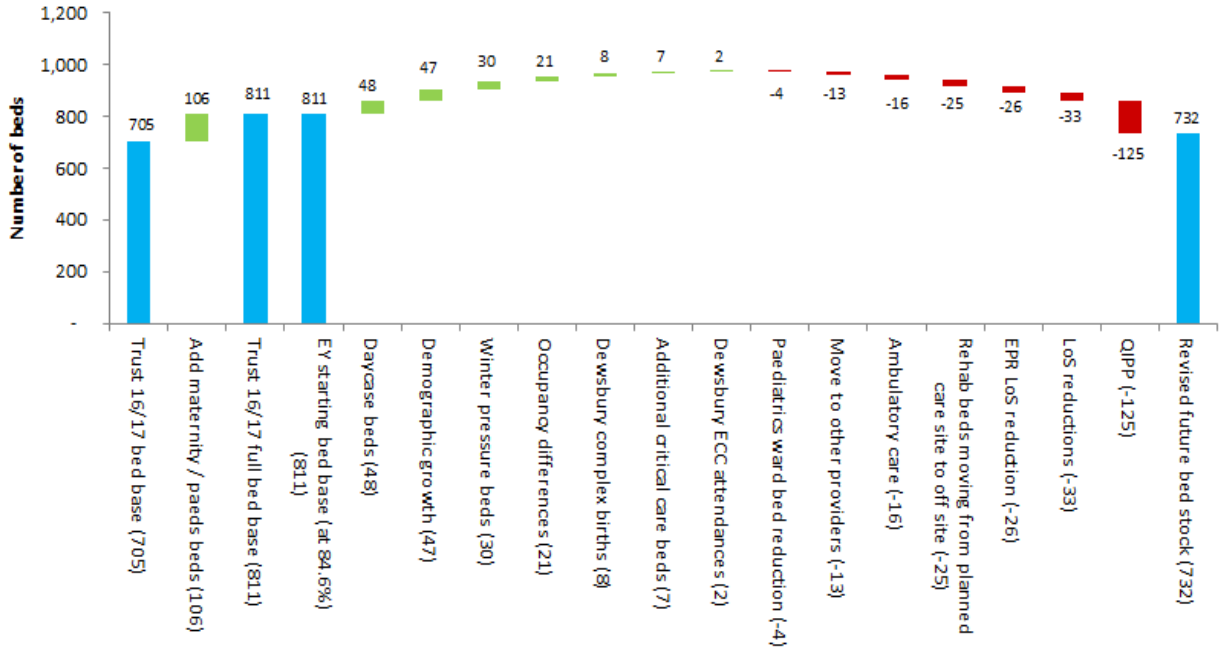


Figure 25: Changes in CHFT bed numbers over the 5 year time horizon if CRH was the unplanned care site

Table **18** and

Table **19** below highlight that there are small differences in divisional-bed numbers for each of the site options as a result of changes to geography and the impact on patient flow.

Division	CRH	HRI	Total
Surgical (excluding critical care)	124	115	239
Critical care	18	0	18
Medical	304	3	307
Paediatrics (includes NICU)	63	0	63
Gynaecology	10	0	10
Maternity	63	2	65
Other (winter pressure beds)	30	0	30
Total	**612**	**119**	**732**

Table 18: Divisional – level beds required at each site if CRH is the unplanned care site

Division	CRH	HRI	Total
Surgical (excluding critical care)	115	127	242
Critical care	0	18	18
Medical	3	302	305
Paediatrics	0	63	63
Gynaecology	0	10	10
Maternity	8	58	66
Other (winter pressure beds)	0	30	30
Total	**126**	**608**	**734**

Table 19: Divisional-level beds required at each site if HRI is the unplanned care site

Figure 26 and Figure 27 show the current versus projected number of divisional-level beds for both site options. (Note: 'Other' category of beds contains winter pressure beds).

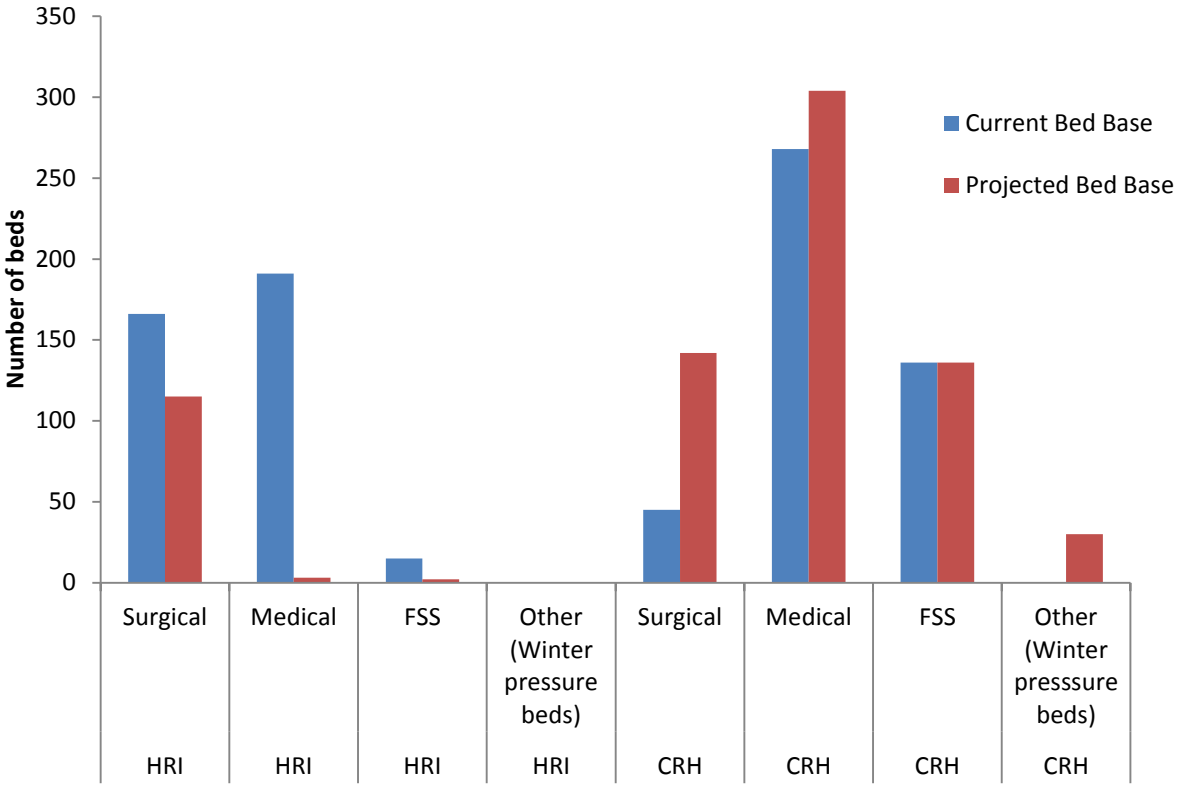


Figure 26: Number of beds required at both sites, by division, if CRH is the unplanned care site

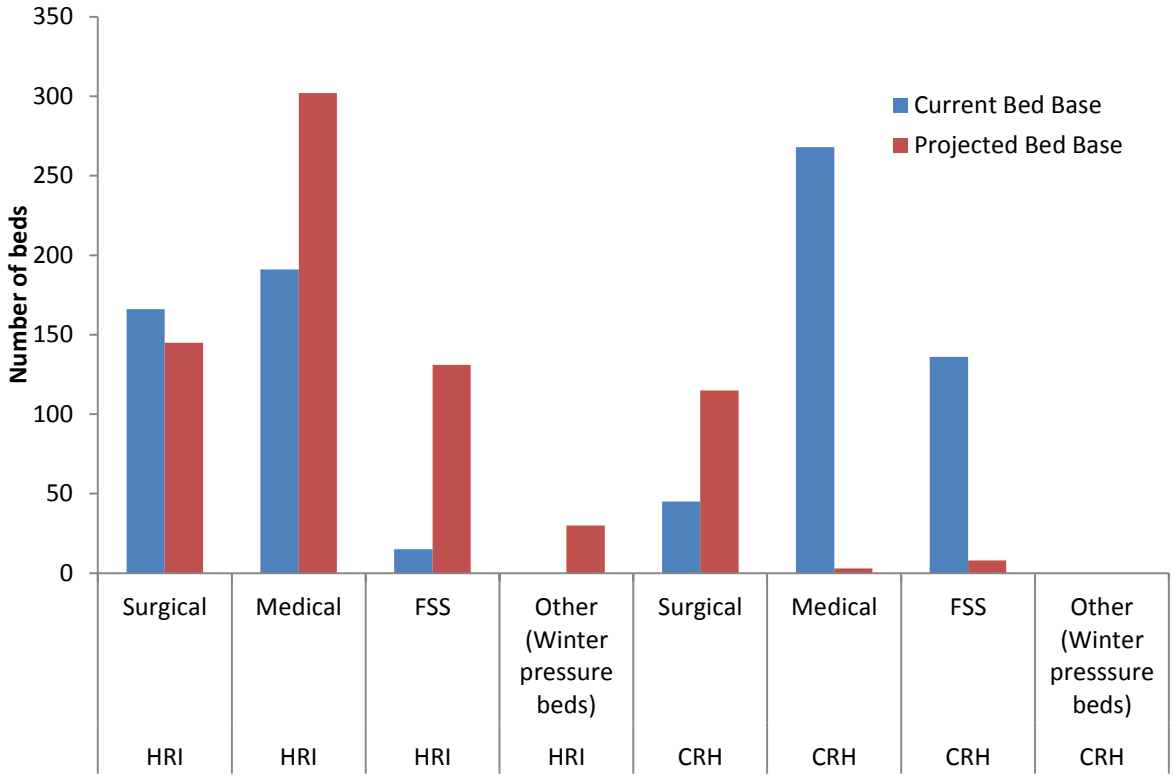


Figure 27: Number of beds required at both sites, by division, if HRI is the unplanned care site

A breakdown of specialty-level beds if CRH is the unplanned care site is included in the appendix.

8.1.11.2 Theatre requirements

The total number of theatre sessions in 5 years' time will be nearly 12,000 theatre sessions per annum for both site options as shown in Table 20. These figures include all day case, elective and non-elective activity.

Option	Huddersfield theatre sessions	Calderdale theatre sessions	Total
HRI unplanned, CRH planned	6,942	5,031	**11,973**
CRH unplanned, HRI planned	5,031	6,889	**11,920**

Table 20: Number of predicted theatre sessions at both sites in 5 years' time. Note, the difference between the two sites is as a result of activity drift to other providers.

The breakdown of theatre sessions by type for each of the site options are summarised in Figure 28 and Figure 29.

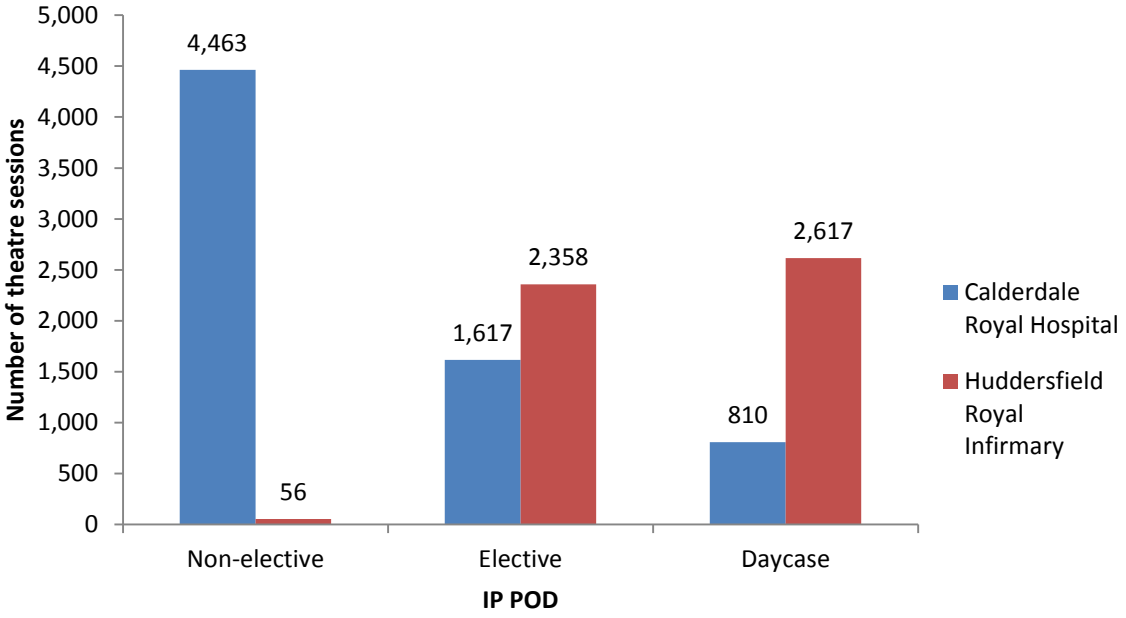


Figure 28: Predicted theatre session breakdown if CRH is the unplanned care site

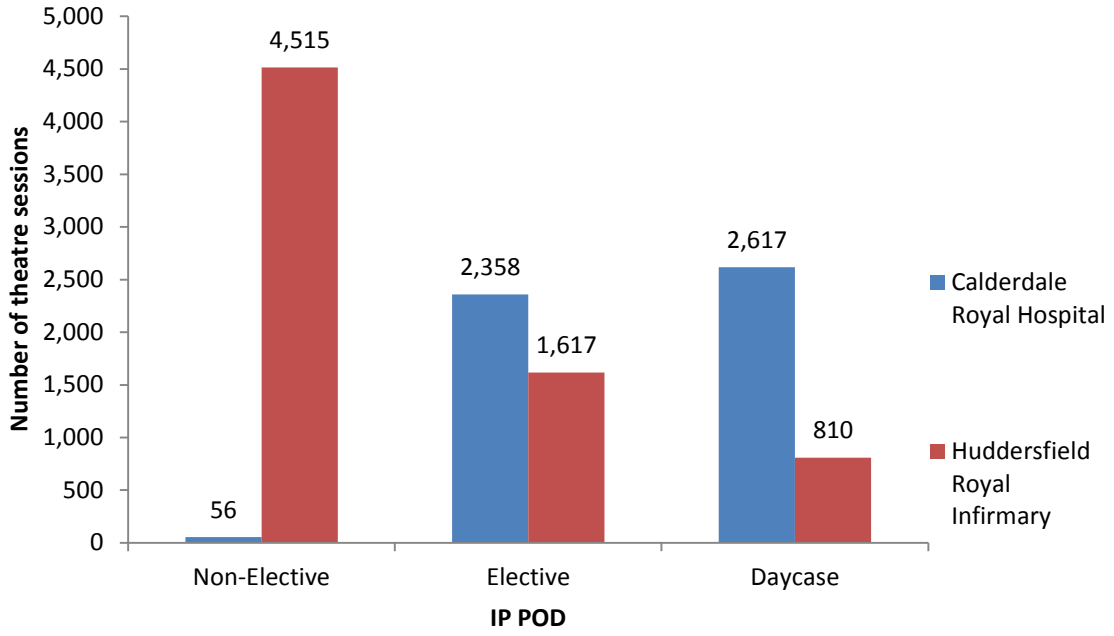


Figure 29: Predicted theatre session breakdown if HRI is the unplanned care site

Assuming that elective theatres will operate two four hour sessions per day over 49 weeks, for both site options (CRH or HRI unplanned) the activity modelling shows that 8 theatres will be required on the unplanned care site and 10 theatres on the planned care site. This includes one 24 hour emergency theatre ('CEPOD'), one trauma theatre and one emergency obstetrics and gynaecology theatre.

Estate option	Non-elective theatres	Elective (other)	Day case theatres	Procedure room	Total
HRI unplanned	3 (CEPOD*, trauma, obs/gynae)	5	0	0	**8**
CRH planned	0	6	3	1	**10**
CRH unplanned	3 (CEPOD*, trauma, obs/gynae)	5	0	0	**8**
HRI planned	0	6	3	1	**10**

Table 21: Predicted future theatre breakdown as informed by the modelling

Note: * The Trust's CEPOD theatre refers to a dedicated 24 hour emergency theatre established in response to the National Confidential Enquiry into Patient Outcome and Death.

8.1.11.3 Emergency attendances

The Clinical Consensus Model proposes a model whereby there will be an urgent care centre co-located at each hospital site. These urgent care centres will operate 24 hours a day and be available to care for adults with minor injuries and illnesses and children over the age of 5 years with minor injuries only.

The modelling indicates that total emergency attendances will not vary significantly under reconfiguration, even with the provision of the urgent care centres.

Site	Age Group	ECC Attendances	UCC Attendances	Total	FY17 ECC
Huddersfield Royal Infirmary	Paediatrics		13,746	13,746	
	Adults		42,180	42,180	
Total Huddersfield Royal Infirmary		**0**	**55,926**	**55,926**	**72,217**
Calderdale Royal Hospital	Paediatrics	19,417	6,999	26,416	
	Adults	58,312	30,391	88,703	
Total Calderdale Royal Hospital		**77,729**	**37,390**	**115,119**	**73,207**

Table 22: Predicted emergency / urgent care activity if CRH is the unplanned care site

Site	Age Group	ECC Attendances	UCC Attendances	Total	FY17 ECC
Huddersfield Royal Infirmary	Paediatrics	19,324	6,509	25,833	
	Adults	58,955	31,089	90,044	
Total Huddersfield Royal Infirmary		**78,279**	**37,598**	**115,877**	**72,217**
Calderdale Royal Hospital	Paediatrics		15,636	15,636	
	Adults		41,585	41,585	
Total Calderdale Royal Hospital		**0**	**57,221**	**57,221**	**73,207**

Table 23: Predicted emergency / urgent care activity if HRI is the unplanned care site

The following charts display the average number of ambulance arrivals by hour and day of the week. The charts show that between midday and 11pm each day, the number of ambulance arrivals are fairly consistent and then considerably drop in the early hours of the morning. It is clear to see that there are increases in the number of arrivals over the weekend.

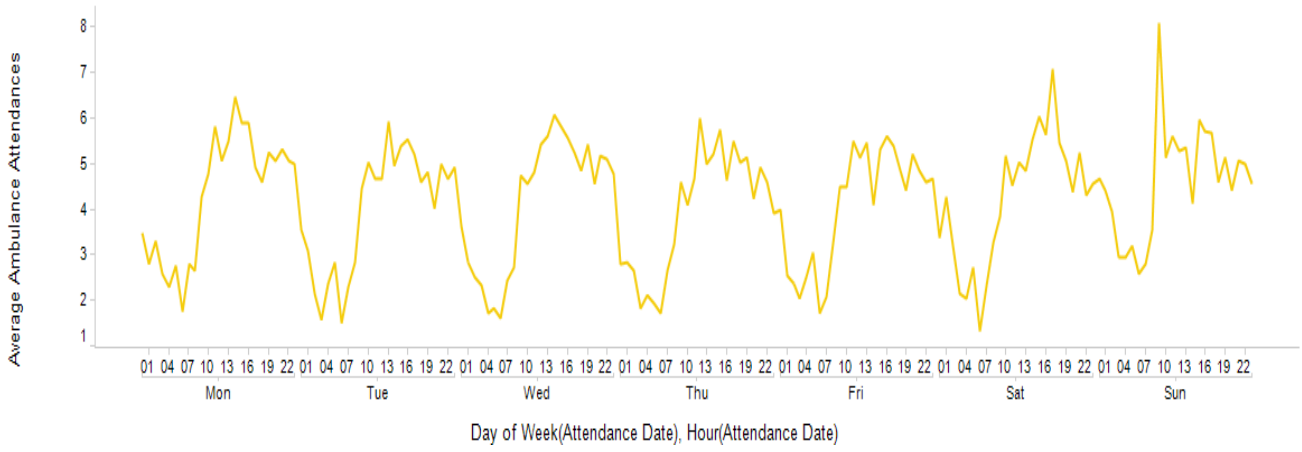


Figure 30: Predicted ambulance arrivals per hour if CRH is the unplanned care site

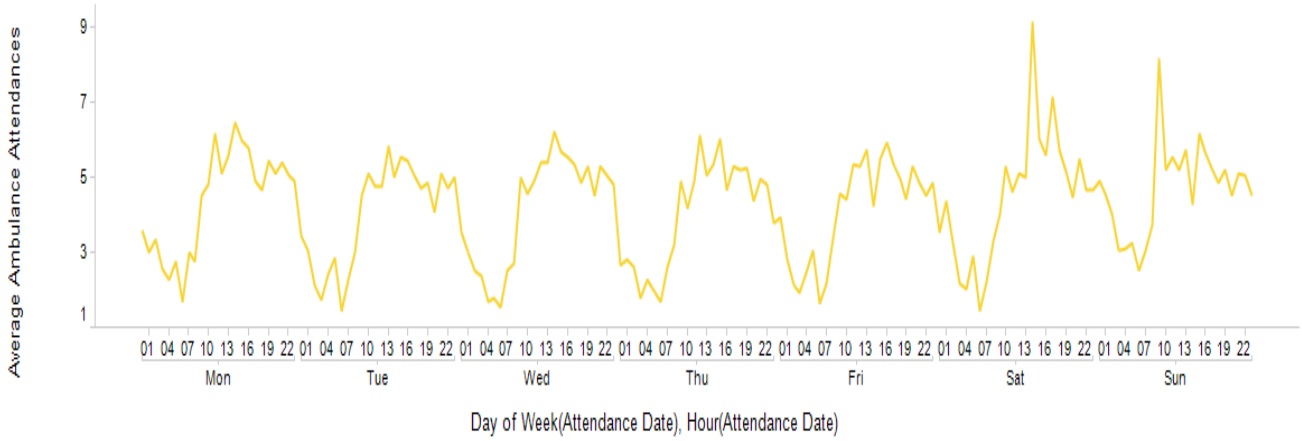


Figure 31: Predicted ambulance arrivals per hour if HRI is the unplanned care site

ECC/UCC attendance profiles for each site option are included in the Appendix 10.5.

8.1.11.4 Births

In the outline model of care for hospital services, each site will continue to have a midwife-led birthing unit. Complex obstetrics will be cared for on the unplanned care site.

The model indicates that there will be a small increase in births at the Trust due to anticipated service changes at neighbouring Dewsbury Hospital. The effect of changes at Dewsbury Hospital have a greater impact if HRI is the unplanned care site due to geography and the likelihood of more patients in the HRI catchment area coming to HRI for their obstetrics needs.

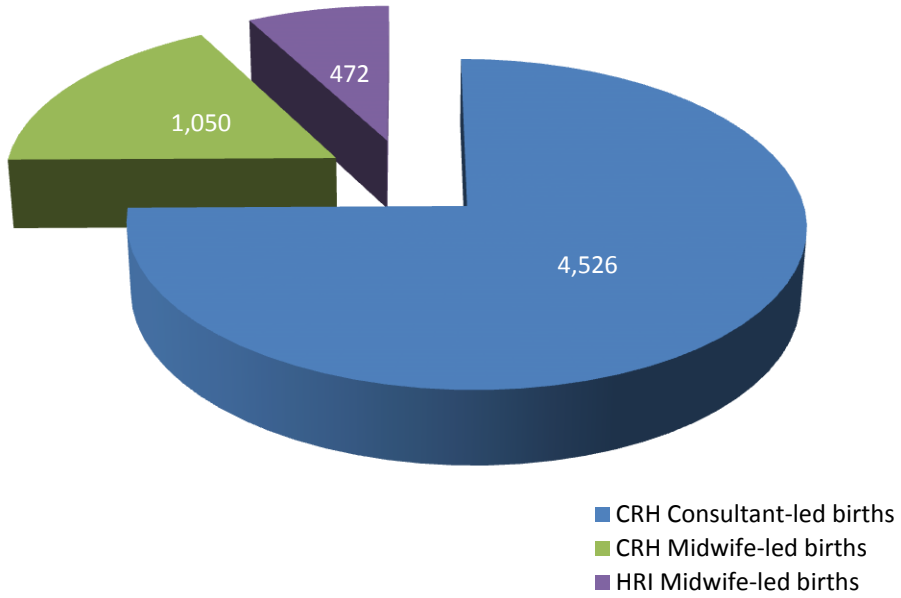


Figure 32: Breakdown of births if CRH is the unplanned care site

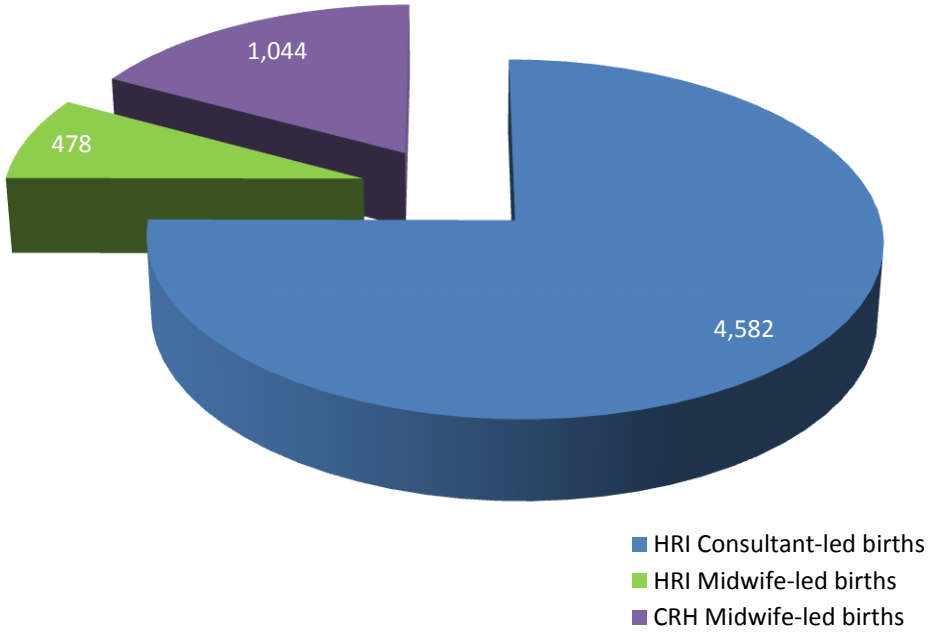


Figure 33: Breakdown of births if HRI is the unplanned care site

8.1.11.5 The impact on other providers

By using the Geographical Information System (GIS) software MapInfo, travel times of patients were calculated to both the Calderdale and Huddersfield sites, along with other local emergency care providers[25] based on patient postcodes from FY16 data. To note, Dewsbury has been excluded from the analysis due to plans to downgrade this site to an Urgent Care Centre.

For all patients that arrived in an ambulance, the travel times were used to determine the closest Emergency Care Centre and it was assumed that patients currently being treated at the planned care site, would be treated at the nearest Emergency Care Centre in the future. These patients are also assumed to have their inpatient care (if required) at the same provider.

The tables below show that the impact of reconfiguration at CHFT will result in activity shifts to neighbouring providers, leading to an increased total bed requirement across neighbouring trusts of 10 beds, irrespective of which site option is selected.

Option 1: HRI is unplanned, CRH is planned

Final Location	Attendances
Bradford Royal Infirmary	1129
Royal Blackburn Hospital	244
Leeds General Infirmary	78
Barnsley District General	30
Pinderfields General Hospital	51
Trafford General Hospital	19
Fairfield General Hospital	6
Pontefract General Infirmary	13
Manchester Royal Infirmary	8
Northern General Hospital	2
St James's University Hospital	8
North Manchester	2
TOTAL	**1,589**

Table 24: Increase in attendance rates at neighbouring trusts as a result of activity drift

[25] The agreed providers to be considered were: Barnsley District General Hospital; Royal Blackburn Hospital; Fairfield General Hospital; Leeds General Infirmary; Trafford General Hospital; Bradford Royal Infirmary; Pontefract General Infirmary; Pinderfields General Hospital; St James's University Hospital; Manchester Royal Infirmary; North Manchester; The Royal Oldham Hospital and Northern General Hospital

Final Location	Beds
Bradford Royal Infirmary	8.4
Royal Blackburn Hospital	1.1
Pinderfields General Hospital	0.2
Barnsley District General	0.2
Pontefract General Infirmary	0.0
Trafford General Hospital	0.0
Northern General Hospital	0.0
Manchester Royal Infirmary	0.1
Leeds General Infirmary	0.2
St James's University Hospital	0.0
North Manchester	0.0
Fairfield General Hospital	0.0
TOTAL	**10 (rounded)**

Table 25: Bed requirements at neighbouring trusts as a result of activity drift

Option 2: CRH is unplanned, HRI is planned

Final Location	Attendances
Barnsley District General	898
Pinderfields General Hospital	675
Royal Blackburn Hospital	19
Bradford Royal Infirmary	330
Leeds General Infirmary	82
Fairfield General Hospital	8
St James's University Hospital	29
Trafford General Hospital	47
Northern General Hospital	12
Pontefract General Infirmary	23
North Manchester	8
Manchester Royal Infirmary	8
TOTAL	**2,139**

Table 26: Increase in attendance rates at neighbouring trusts as a result of activity drift

Final Location	Beds
Barnsley District General	5.0
Pinderfields General Hospital	4.9
Bradford Royal Infirmary	2.4
Leeds General Infirmary	0.3
St James's University Hospital	0.0
Royal Blackburn Hospital	0.1
Trafford General Hospital	0.2
Pontefract General Infirmary	0.1
Northern General Hospital	0.0
Fairfield General Hospital	5.0
TOTAL	**13 (rounded)**

Table 27: Bed requirements at neighbouring trusts as a result of activity drift

A mapping of the sources of this activity drift, together with choice of alternative provider (based on travel time) is shown below:

The map chart displays the locations of patients that are currently arriving by ambulance at the cold site and is colour coded (see the legend on the chart) by the location of where they will be diverted to in the future. Due to the close proximity of Calderdale Royal Hospital and Huddersfield Royal Infirmary the majority of patients will remain within the Trust.

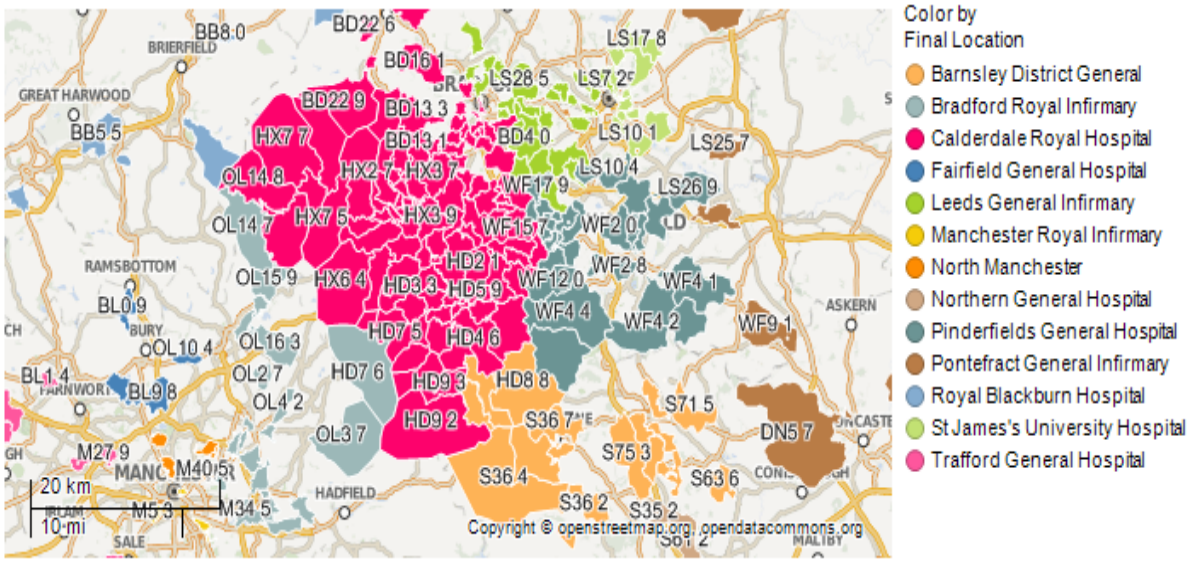


Figure 34: Mapping of forecast change in attendances if CRH is the unplanned care site

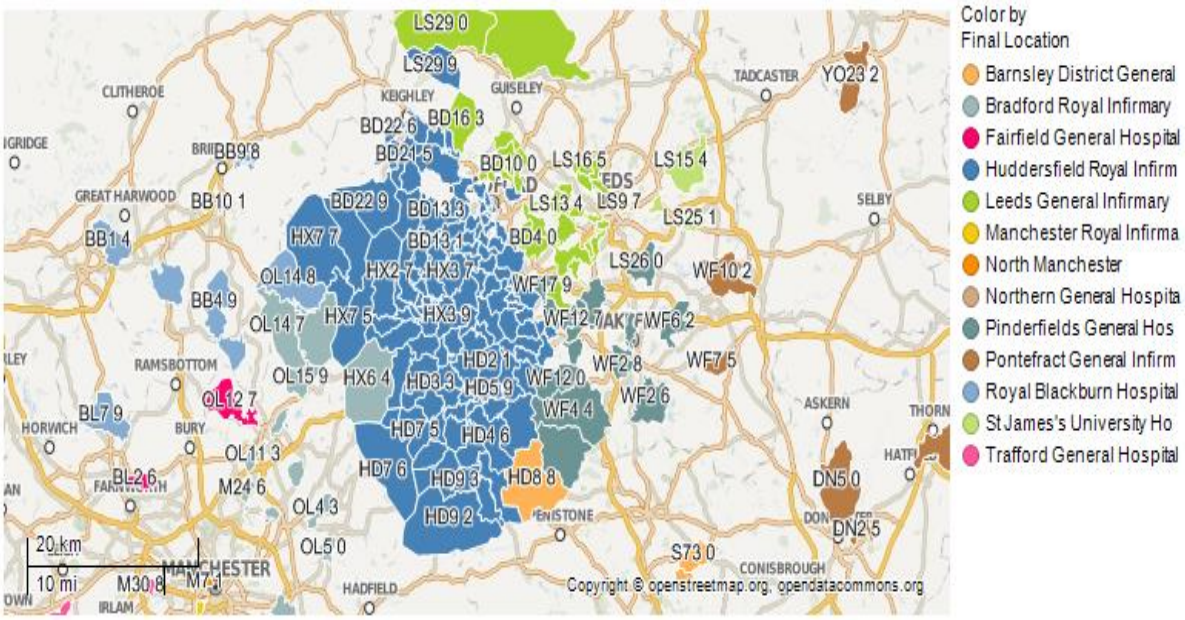


Figure 35: Mapping of forecast change in attendances if HRI is the unplanned care site

8.2 Financial

The preferred option yields a recurrent deficit of £9.5m from FY22 onwards. Whilst this represents an improvement of £18.0m against the Base Case deficit of £27.5m in FY22 (including strategic initiatives, but excluding reconfiguration savings), this option does not return the Trust to a breakeven or surplus position over the forecast period.

Key assumptions and findings relating to the preferred options include:

- **1-2% annual activity growth.** Non-elective growth has been assumed at c. 1%. Any variation from this will need to be managed at a health economy level through additional Commissioner QIPP.
- **Delivery of CIP targets that offset the annual efficiency requirement, equivalent to £54.4m between FY17 and FY22.**
- **Successful local health economy delivery of a 6% annual reduction in Non Elective Medical Admissions over each of the 5 years – a significant target.**
    - This has been assumed to be offset by an equal level of cost reduction within the Trust and equates to a real term reduction of c.£2.5m per annum.
- **Successful delivery of £18.0m in net recurrent annual savings from the reconfiguration, with a further £7.4m independent of the reconfiguration** (in nominal terms).
    - If HRI is the unplanned care site, the equivalent annual savings from reconfiguration are £14.7m, and non-reconfiguration related savings are £7.4m, consistent with the CRH unplanned care site option.
    - The £3.3m difference on reconfiguration savings relates to estates operating costs, whereby the full cost saving is achieved from closing HRI whilst only partial costs can be saved from closing CRH owing to the PFI arrangements.
- **Securing external funding support of £478.8m made up of**:
    - £354.8m in loan funding to support the capital requirement.
    - £9.1m in non-recurrent reconfiguration revenue costs funding.
    - £115.0m non-recurrent deficit support funding.
- **Subject to securing the external funding support as above, the Trust's income and expenditure and cash position are forecast to be sufficient to support the Trust's interest and repayment obligations.**
- **Incremental annual costs of providing an urgent care facility at a third site, such as Todmorden, are estimated at £1.2m and have not been included in any of the options.**
- **Finance assumptions have been revised for DH technical financial planning guidance published in early 2016. This has not impacted the financial option appraisal.**

8.2.1 Introduction to the Financial Case

This section sets out the forecast financial position of CHFT for FY17 and the subsequent five year period. Specifically, it covers:

- Forecast methodology and overview of assumptions;
  - FY17 Plan;
  - Growth assumptions;
  - Financial assumptions;
  - Economic assumptions;
  - Capital assumptions.
- Forecast financial performance under each option;
  - Summary of the options;
  - Do Nothing option;
  - Strategic savings only option;
  - HRI as the site for unplanned care;
  - CRH as the site for unplanned care.
- Capital expenditure under each option;
- Funding requirements for each option;
- Sensitivity analysis;
- Conclusions to the Financial Case.

8.2.2 Forecast methodology and overview of assumptions

8.2.2.1 FY17 Plan

8.2.2.1.1 Income & Expenditure

The Financial Case is underpinned by the Trust's draft Plan for FY17. The starting point for the Five Year Strategy was the draft FY17 Plan that was presented to Monitor on 24 November 2015. This Plan shows a deficit for the year of £33.0m[26]:

[26] The Trust has brought forward its usual annual planning process in order to fulfil this Five Year Strategic Plan. As such, annual planning is ongoing at the time of writing this document. The Trust plan for FY17 will continue to evolve as trading continues in FY16, until the Trust is required to formally submit its plan to Monitor in line with its timescales.

£m	FY17 Plan
Income	361.2
Pay	(241.7)
Non Pay	(126.5)
EBITDA	**(7.0)**
Non-Operating Expenditure	(26.0)
Surplus/(Deficit)	**(33.0)**

Table 28 - Summary FY17 Draft I&E

Key assumptions underpinning the FY17 Plan

The FY17 position assumes the Trust delivers £13.6m in CIP, £13.0m recurrently and £0.6m non-recurrently. The Trust's deficit prior to CIP achievement is £46.6m, or 12.9% of its income.

The Trust has included £1.0m for the initial implementation of seven-day working in FY17. This is considered discretionary and therefore attracts no additional funding, meaning this represents a cost pressure to the Trust.

Accounting for changes in National Insurance contributions means that the Trust incurs a £3.1m cost pressure. A further increase in Clinical Negligence Scheme for Trusts (CNST) contributions drives an additional £4.6m cost pressure through the I&E.

The FY17 Plan I&E makes a number of key assumptions:

- **Impact of EPR implementation –** a possible £5.0m clinical income risk associated with the EPR implementation. This is due to a potential loss in productivity during the implementation of the new patient record system. This is based on experience of other providers implementing a similar system. The Trust will continue to explore mitigations to this position;
- **Pathway changes –** pathway changes associated with Respiratory Medicine, Deep Vein Thrombosis (DVT) and Stroke Rehabilitation have not been included in the FY17 position. This is because the impact has yet to be agreed with commissioners and the Trust has included an additional £2.0m contingency against its income in any case.

8.2.2.1.2 Balance Sheet

The deficit on the draft I&E causes a deterioration of the Trust's cash position. The draft FY17 planned balance sheet shows a cash deficit of £47.9m following an additional £10.0m drawdown against its Independent Trust Financing Facility (ITFF) loan. This is based on the Trust's capital plan that was submitted to DH in January 2015 and is before any consideration is made for capital expenditure associated with any major building works for the hospital reconfiguration (see section 8.2.4 for further detail on the Trust's capital position).

£m	FY17 Plan
Property, Plant and Equipment	**238.2**
Inventories	6.1
NHS Trade Receivables	3.2
Non NHS Trade Receivables	2.3
Other Current Assets	10.8
Cash and Cash Equivalents	(47.9)
Current assets	**(25.4)**
Total assets	**212.8**
Current Liabilities	**(40.7)**
Non-Current Liabilities	**(100.0)**
Total Liabilities	**(140.7)**
Net assets employed	**72.1**
Public dividend capital	115.7
Retained Earnings (Accumulated Losses)	(79.6)
Donated asset reserve	-
Revaluation reserve	36.1
Miscellaneous reserves	-
Total taxpayers' equity	**72.1**

Table 29 - FY17 Summary draft Balance Sheet

8.2.2.2 Growth assumptions

CHFT has undertaken an activity forecasting exercise to understand the likely impact of demographic growth. Table 30 shows the demographic growth assumptions used by the Trust. Non-demographic factors have also been incorporated.

Discussions have been held with the Trust's two main commissioners, Greater Huddersfield CCG (GHCCG) and Calderdale CCG (CCCG), to ascertain any material differences in forecasting assumptions. The Trust and CCGs' assumptions on activity growth appear to be materially consistent, with the main differences being in relation to QIPP. See the commercial case in Section 8.4 for further detail on the comparison between Trust and Commissioner forecasts.

Point of delivery	FY17	FY18	FY19	FY20	FY21	FY22
Elective	1.33%	1.33%	1.33%	1.15%	1.15%	1.15%
Day case	1.28%	1.28%	1.28%	1.06%	1.06%	1.06%
Non-elective	0.96%	0.96%	0.96%	0.99%	0.99%	0.99%
Outpatient	1.09%	1.09%	1.09%	1.00%	1.00%	1.00%
A&E	0.73%	0.73%	0.73%	0.81%	0.81%	0.81%
Other tariff	1.02%	1.02%	1.02%	0.96%	0.96%	0.96%
Non-tariff	1.02%	1.02%	1.02%	0.96%	0.96%	0.96%
Community	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%

Table 30 - Activity demographic growth assumptions by PoD

The CCGs have identified circa 1.5% of income reduction associated with planned QIPP. The Trust has assumed QIPP of approximately 0.7% per annum over the years FY17 to FY22, based on a 6.0% reduction in non-elective medical admissions. The QIPP incorporated into the Trust's plan results in a total of £2.8m reduction in income in FY18, falling to £2.2m in FY22 and totalling a £12.4m income reduction across FY18 to FY22.

The Trust and its Commissioners have agreed to continue discussions to work up detailed plans to more accurately reflect the impact of QIPP schemes on CHFT's income through the period.

8.2.2.3 Financial assumptions

The projections laid out in the Financial Case include a number of assumptions around how the Trust operates:

- **Pay/Non-pay split** – where costs have not been able to be directly attributed to pay and non-pay categories, these have been split on a 80/20 ratio.
- **Marginal cost –** the assumption has been that any growth or movement in activity, other than QIPP, will have a marginal cost impact of 70%.
- **QIPP –** the Trust has assumed 100% marginal cost associated with activity lost through QIPP schemes. As such, QIPP does not have a negative impact on contribution.
- **Working capital –** none of the options is assumed to have any significant impact on the Trust's working capital policy (i.e. payables and receivables days remain constant throughout the Plan period).

8.2.2.4 Economic assumptions

The Trust has also made a number of economic assumptions governing cost inflation and tariff deflation. These are presented below.

Assumptions	FY17	FY18	FY19	FY20	FY21	FY22
Income	1.1%	-1.0%	-0.6%	-0.6%	-0.6%	-0.6%
Pay	1.0%	1.0%	1.0%	1.0%	2.0%	2.0%
Incremental drift	1.0%	0.75%	0.0%	0.0%	0.0%	0.0%
Drugs	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Clinical Supplies & Other non-pay	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%

Table 31 - CHFT economic planning assumptions

The bases for these assumptions are as follows:

- **Tariff deflation** – tariff deflation has been assumed to be between 0.6% and 1.8% throughout the period FY18 to FY22. The tariff has been assumed to inflate by 1.1% for FY17 in line with the latest planning guidance;
- **Pay inflation** – pay inflation for all staff is assumed to rise to 2.0% per annum by FY21. However, the 1.0% and 0.75% incremental drift pressures arising in FY17 and FY18 cease from FY19 onwards;
- **Drugs** – the figures presented above are for routine pharmacy drug issues and represent a cost pressure to the Trust. Inflation relating to high-cost drugs, which are pass-through in nature, is assumed to be 14.0% per annum.

These assumptions were based on the information available to the Trust at the time of developing the Plan – these assumptions will be revisited following the DH's publication of technical guidance on financial planning, due in early 2016. This will not impact the financial option appraisal since changes to such assumptions will impact all options equally.

8.2.2.5 Capital assumptions

Estimates for capital expenditure were obtained from the work undertaken by Lendlease Consulting. Capital expenditure estimates are based on the gross internal floor areas of the respective buildings, taken from the Schedule of Accommodation produced by the Healthcare Planner following confirmation of the proposed service changes under each option.

- **Impairment of capital expenditure** under the two reconfiguration options, a 15% impairment of the expenditure on new works (i.e. capital expenditure excluding backlog maintenance) is assumed on completion of the works (in FY20);
- **Depreciation policy for capital expenditure**
  - Backlog maintenance – depreciated over 30 years, except where CRH is the site for delivering unplanned care. In this case, the capital is depreciated over the three years prior to the disposal of buildings on the HRI site;
  - Reconfiguration capital – depreciated over 40 years;
- **Asset disposals –** the disposal of assets on the HRI site under the CRH delivering unplanned care option occurs in FY21. The disposal proceeds of £7m is based on external quantity surveyor reports. Losses on disposal are based on projected net replacement costs from the Trust's Fixed Asset Register (FAR);
- **Capital estimate inclusions –** all of the below are pro-rated across the breakdown of capital provided by the Quantity Surveyor:

- Preliminary costs – 14%;
- Professional fees – 12%;
- Non-works costs – 1.5%;
- Capital equipment costs – 5%;
- Planning contingency – 15%;
- Optimism bias – 13%;
- Value Added Tax (VAT) – 20%;

- **Revaluations –** no revaluation gains or losses have been assumed during the period covered by the Plan;
- **Financing assumptions**
  - Financing of capital expenditure has been assumed to be through loans raised with the Independent Trust Financing Facility (ITFF). It is appreciated that this may not be the optimal source of financing, but it has been deemed prudent to assume that Public Dividend Capital (PDC) funding will not be available for capital works in the current economic climate;
  - New loan agreements are assumed to be profiled over a 40-year repayment period. This is reflected in the Equal Instalments of Principal (EIP) National Loan Fund rate of 2.54%. Interest repayment commences on drawdown from FY17, with principal repayment beginning in FY20 on completion of works;
  - **Private Finance Initiative (PFI) impact –** it has been assumed that under the HRI unplanned care site option, a 50% reduction in soft facilities management payments and a one third reduction in utilities payments will be achievable. This will need to be negotiated with the PFI provider. No other changes in PFI related costs have been assumed in the remaining options (with the exception of the standard inflation on unitary charge).
- **Urgent Care Centre at Todmorden –** all of the options exclude the expected £1.2m of costs to run an Urgent Care Centre at the Trust's Todmorden site.

8.2.3 Forecast financial performance under each option

This section provides detail on how the Clinical Model and financial assumptions presented above feed into the financial forecasts under each option. The capital appraisal will be undertaken in section 8.2.4.

8.2.3.1 Summary of the options

This section presents a brief summary of the forecast financial performance of CHFT under each option. More detail on the individual options is presented in each subsequent section.

In terms of how the options have been incorporated into the financial assessment, the following descriptions are relevant:

- **Do Nothing –** Do Nothing refers to the rolling forward of the FY17 Plan position given the above activity, financial and economic assumptions. In each year, the Trust is assumed to meet its efficiency requirement via CIP. This is an average of £8.7m per annum between FY17 and FY22;

- **Strategic Initiatives Savings –** in this option, the Trust rolls-forward its financial position as above. In addition to achieving CIPs, the Trust delivers additional savings from the Strategic Initiatives that are presented in Section 8.2.3.3;
- **HRI as the site for delivering unplanned care –** this option assumes services are reconfigured so that unplanned care is delivered from Huddersfield Royal Infirmary. Planned care is thus delivered from Calderdale Royal Hospital. This reconfiguration generates savings (outlined in Section 8.2.3.4) that are in addition to CIP and savings from the Strategic Initiatives;
- **CRH as the site for delivering unplanned care –** this is as above, but with unplanned care being delivered from CRH and planned care from HRI. This generates its own set of reconfiguration savings, outlined in Section 8.2.3.5.

Table 32 below summarises the I&E position in FY22 and the cumulative cash position and funding requirement for the years FY17-FY22. The surplus/(deficit) position is a recurrent position for the Trust and includes the full impact of all savings identified under each option.

£m (Nominal)	Do Nothing	Strategic initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
EBITDA	5.4	12.8	27.2	30.4
Surplus/(deficit)	(31.2)	(27.5)	(21.6)	(9.5)
Strategic savings	-	7.4	7.4	7.4
Reconfiguration savings Made up of:	-	-	14.7	18.0
- Net cost savings	-	-	*14.9*	*18.3*
- Loss of contribution as a result of activity displacement	-	-	*(0.2)*	*(0.3)*
Cumulative cash position	(217.0)	(188.0)	(200.2)	(178.6)
Total funding requirement	217.0	280.4	509.1	478.8

Table 32 - Summary financial forecasts for each option as at FY22

The financial appraisal does not take into consideration the estimated £1.2m of costs that would be required if a UCC were to be operated out of the Trust's Todmorden site.

Table 32 above demonstrates that opting for CRH as the unplanned site delivers the most favourable I&E position (assuming the there is no significant financial impact from the PFI at that site under this option), with a £9.5m deficit in FY22 compared to £31.2m under the Do Nothing option. The table below summarises the key movements between the Do Nothing case and each of the other options.

£m (Nominal)	Strategic initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
FY22 Do Nothing Surplus/ (Deficit)	**(31.2)**	**(31.2)**	**(31.2)**
Depreciation	(3.3)	(7.8)	(3.0)
Capital Loan Interest	(2.0)	(6.5)	(6.3)
PDC	0.7	1.5	4.8
Working capital interest	0.9	0.3	0.8
Strategic savings	7.4	7.4	7.4
Reconfiguration savings	-	14.7	18.0
FY22 Surplus / (Deficit)	**(27.5)**	**(21.6)**	**(9.5)**

Table 33 – Bridge from Do Nothing to each of the options

The preferred option yields the most preferable forecast EBITDA. CRH as the site for unplanned care delivers an EBITDA of £30.4m in FY22, compared with £27.2m with HRI as the unplanned care site. For the Do Nothing scenario, there is an EBITDA of £5.4m, whilst the Strategic Initiatives savings deliver a £12.8m EBITDA position.

The lowest cash deficit arises from CRH being the site delivering unplanned care due to its lower capital requirement than for HRI. This is coupled with the more favourable I&E position generating more cash for the Trust.

The least favourable option is the Do Nothing option – this option assumes CIP savings the Trust generates are sufficient to meet its efficiency requirement. Operationally, clinically (see Section 8.1) and financially, this option is not considered viable.

The remaining three options each deliver operational cash savings of £26.2m over five years from the implementation of the Strategic Initiatives outlined in Section 8.1 of the Clinical Model. The reconfiguration options add additional savings which improve both forecast cash and financial performance.

All of the options leave the Trust with a Continuity of Services Risk Rating (CoSRR) of 1 due to its debt profile and cash shortage.

8.2.3.2 Do Nothing option

Under the Do Nothing option, CHFT continues to operate on the same basis as it does today. The Clinical Model sees unplanned care being delivered across both sites as the Trust aims to meet its annual efficiency requirement through delivery of CIPs.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Clinical Revenue	327.7	325.7	325.2	324.6	324.1	323.8
Non Protected/Non Mandatory Clinical Revenue	4.9	4.9	4.9	4.9	4.9	4.9
Other Revenue	28.6	32.9	32.9	32.9	32.9	32.9
Total Revenue	**361.2**	**363.5**	**362.9**	**362.3**	**361.9**	**361.6**
Employee Benefit Expenses	**(241.7)**	**(236.9)**	**(233.7)**	**(230.5)**	**(227.9)**	**(225.4)**
Drugs	(31.9)	(32.2)	(32.5)	(32.8)	(33.1)	(33.5)
Clinical Supplies & Services	(34.4)	(33.3)	(34.3)	(35.3)	(36.4)	(37.6)
Other Expenses	(48.2)	(46.9)	(46.9)	(46.8)	(46.3)	(45.7)
PFI Operating Expenses	(12.1)	(12.5)	(12.8)	(13.2)	(13.6)	(14.0)
Total Operating Expenditure	**(368.2)**	**(361.8)**	**(360.2)**	**(358.8)**	**(357.4)**	**(356.2)**
EBITDA	**(7.0)**	**1.7**	**2.7**	**3.6**	**4.5**	**5.4**
EBITDA Margin (%)	*-2.0%*	*0.5%*	*0.7%*	*1.0%*	*1.2%*	*1.5%*
Gain/(loss) on asset disposals	0.0	-	-	-	-	-
Impairment Losses (Reversals) net	-	-	-	-	-	-
Total Depreciation & Amortisation	(10.5)	(11.0)	(11.8)	(12.9)	(12.9)	(12.9)
Interest expense on overdrafts and working capital facilities	(0.6)	(2.3)	(3.4)	(4.6)	(5.8)	(6.9)
Total interest payable on Loans and leases	(11.6)	(11.5)	(11.5)	(11.8)	(11.9)	(11.9)
PDC Dividend	(3.3)	(4.4)	(4.5)	(4.7)	(4.8)	(4.8)
Total Non-operating Expenses	**(26.0)**	**(29.2)**	**(31.2)**	**(33.9)**	**(35.3)**	**(36.6)**
Net Surplus / (Deficit)	**(33.0)**	**(27.5)**	**(28.5)**	**(30.4)**	**(30.9)**	**(31.2)**
Net Surplus / (Deficit) margin (%)	*-9.1%*	*-7.6%*	*-7.9%*	*-8.4%*	*-8.5%*	*-8.6%*

Table 34 - Do Nothing option I&E forecast

Table 34 shows the deterioration of the I&E through to FY22, ending with a £31.2m deficit at 8.6% of total income. This drives a worsening of the cash position thereby increasing the Trust's interest expense, causing the deficit to increase still further.

The cumulative impact of the declining I&E position results in the balance sheet moving into negative assets / equity by FY19, as shown by Table 35.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Property, Plant and Equipment	238.2	241.3	242.5	244.9	244.1	243.2
Inventories	6.1	6.1	6.1	6.1	6.1	6.1
NHS Trade Receivables	3.2	3.2	3.2	3.2	3.2	3.2
Non NHS Trade Receivables	2.3	2.3	2.3	2.3	2.3	2.3
Other Current Assets	10.8	10.8	10.8	10.8	10.8	10.8
Cash and Cash Equivalents	(47.9)	(83.0)	(115.6)	(151.0)	(183.7)	(217.0)
Current assets	(25.4)	(60.5)	(93.1)	(128.5)	(161.2)	(194.5)
Total assets	212.8	180.8	149.4	116.4	82.8	48.7
Current Liabilities	(40.7)	(39.4)	(39.5)	(39.7)	(40.0)	(40.1)
Non-Current Liabilities	(100.0)	(96.7)	(93.9)	(91.0)	(87.9)	(84.9)
Total Liabilities	(140.7)	(136.2)	(133.4)	(130.7)	(127.9)	(125.0)
Net assets employed	**72.1**	**44.6**	**16.1**	**(14.3)**	**(45.1)**	**(76.4)**
Public dividend capital	115.7	115.7	115.7	115.7	115.7	115.7
Retained Earnings (Accumulated Losses)	(79.7)	(107.2)	(135.7)	(166.0)	(196.9)	(228.1)
Donated asset reserve	-	-	-	-	-	-
Revaluation reserve	36.1	36.1	36.1	36.1	36.1	36.1
Miscellaneous reserves	-	-	-	-	-	-
Total taxpayers' equity	**72.1**	**44.6**	**16.1**	**(14.3)**	**(45.1)**	**(76.4)**

Table 35 - Do Nothing option balance sheet forecast

The Do Nothing option balance sheet highlights that continuing as-is is not financially sustainable. Successive deficits yield a considerable net liability/negative equity position of £76.4m by FY22.

This option is yields the worst final year deficit position, and is deemed clinically unsustainable (see Section 8.1).

8.2.3.3 Strategic Initiatives Savings Only option

The financial position of the Strategic Initiatives Savings Only option is reliant upon the Trust achieving £12.1m of operational savings annually by FY22, in nominal terms. These are broken down in Table 36 below:

£m (Nominal)	FY18	FY19	FY20	FY21	FY22
CIP	8.2	7.0	7.0	9.3	9.3
QIPP	2.8	2.7	2.6	2.5	2.4
Strategic savings	1.1	2.6	3.3	-	0.4
Total non-reconfiguration savings	**12.1**	**12.3**	**12.9**	**11.8**	**12.1**

Table 36 - non-reconfiguration savings

The Strategic Savings Only option does not involve any service reconfiguration but does overlay savings and cost pressures arising from strategic initiatives which do not require reconfiguration, onto the Do Nothing position. This generates a net saving to the Trust of £7.4m per annum by

FY22. These savings are in addition to the Trust's CIP requirement each year, as detailed in Table 37.

Initiative	Net savings Strategic initiatives (£m) (Real)	
Develop / invest in strategic partnerships (e.g. GP Federation, voluntary sector, other organisations)	0.2	
Enhancing productivity in and through community work	0.1	
Investment in service improvement capability such as Lean & Fellowships with IHI / Kings Fund/ Birmingham University	0.7	
Optimise information technology benefits	3.6	
Workforce and skills planning	0.8	
Identification of service development opportunities to ensure we maximise income for the Trust	1.4	Nominal value of savings (£m)
TOTAL	**6.7**	**7.4**

Table 37 - Savings arising from the strategic initiatives in FY22

The deficit position under this option is improved by £3.7m (in nominal terms) compared with the Do Nothing option, from £31.2m to £27.5m. The savings shown above are offset by an increase in depreciation (£3.3m) and capital loan interest payments (£2.0m) as well as a reduction in PDC and working capital interest payments (£1.6m).

£m	FY17	FY18	FY19	FY20	FY21	FY22
Clinical Revenue	327.7	325.8	325.3	326.0	325.6	325.3
Non Protected/Non Mandatory Clinical Revenue	4.9	4.9	4.9	4.9	4.9	4.9
Other Revenue	28.6	32.9	32.9	32.9	32.9	32.9
Total Revenue	**361.2**	**363.6**	**363.1**	**363.8**	**363.4**	**363.1**
Employee Benefit Expenses	(241.7)	(236.4)	(231.8)	(227.9)	(225.3)	(222.7)
Drugs	(31.9)	(32.2)	(32.5)	(32.8)	(33.1)	(33.5)
Clinical Supplies & Services	(34.4)	(33.2)	(34.0)	(34.3)	(35.4)	(36.3)
Other Expenses	(48.2)	(46.5)	(45.6)	(45.0)	(44.4)	(43.8)
PFI Operating Expenses	(12.1)	(12.5)	(12.8)	(13.2)	(13.6)	(14.0)
Total Operating Expenditure	**(368.2)**	**(360.8)**	**(356.8)**	**(353.2)**	**(351.8)**	**(350.3)**
EBITDA	**(7.0)**	**2.8**	**6.3**	**10.6**	**11.5**	**12.8**
EBITDA Margin (%)	*-2.0%*	*0.8%*	*1.7%*	*2.9%*	*3.2%*	*3.5%*
Gain/(loss) on asset disposals	0.0	-	-	-	-	-
Impairment Losses (Reversals) net	-	-	-	-	-	-
Total Depreciation & Amortisation	(11.1)	(12.3)	(13.7)	(15.5)	(16.2)	(16.3)
Interest expense on overdrafts and working capital facilities	(0.6)	(2.2)	(3.1)	(3.9)	(4.9)	(6.0)
Total interest payable on Loans and leases	(11.8)	(12.2)	(12.8)	(13.5)	(13.9)	(13.9)
PDC Dividend	(4.1)	(4.2)	(4.1)	(4.0)	(4.1)	(4.2)
Total Non-operating Expenses	**(27.6)**	**(30.9)**	**(33.7)**	**(37.0)**	**(39.1)**	**(40.3)**
Net Surplus / (Deficit)	**(34.6)**	**(28.1)**	**(27.4)**	**(26.4)**	**(27.6)**	**(27.5)**
Net Surplus / (Deficit) margin (%)	*-9.6%*	*-7.7%*	*-7.5%*	*-7.3%*	*-7.6%*	*-7.6%*
Normalised (excluding impairments / Disposals)	**(34.6)**	**(28.1)**	**(27.4)**	**(26.4)**	**(27.6)**	**(27.5)**

Table 38 – Strategic Savings Initiatives only I&E forecast

The improved I&E position results in an improvements to the balance sheet position, in particular to cash which is £29.0m higher in FY22 than the 'Do Nothing' option.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Property, Plant and Equipment	256.1	271.7	282.8	294.5	309.1	304.9
Inventories	6.1	6.1	6.1	6.1	6.1	6.1
NHS Trade Receivables	3.2	3.2	3.2	3.2	3.2	3.2
Non NHS Trade Receivables	2.3	2.3	2.3	2.3	2.3	2.3
Other Current Assets	10.8	10.8	10.8	10.8	10.8	10.8
Cash and Cash Equivalents	(48.9)	(78.6)	(101.7)	(127.8)	(158.0)	(188.0)
Current assets	(26.4)	(56.2)	(79.2)	(105.3)	(135.5)	(165.5)
Total assets	229.7	215.5	203.6	189.2	173.6	139.4
Current Liabilities	(40.7)	(39.4)	(43.0)	(43.1)	(43.4)	(43.5)
Non-Current Liabilities	(118.4)	(133.7)	(145.6)	(157.5)	(169.3)	(162.5)
Total Liabilities	(159.1)	(173.1)	(188.6)	(200.6)	(212.6)	(206.0)
Net assets employed	**70.5**	**42.4**	**15.0**	**(11.5)**	**(39.1)**	**(66.6)**
Public dividend capital	115.7	115.7	115.7	115.7	115.7	115.7
Retained Earnings (Accumulated Losses)	(81.3)	(109.4)	(136.8)	(163.2)	(190.8)	(218.4)
Donated asset reserve	-	-	-	-	-	-
Revaluation reserve	36.1	36.1	36.1	36.1	36.1	36.1
Miscellaneous reserves	-	-	-	-	-	-
Total taxpayers' equity	**70.5**	**42.4**	**15.0**	**(11.5)**	**(39.1)**	**(66.6)**

Table 39 - Strategic Initiatives Savings only option I&E forecast

Despite the improvement in the I&E position, the balance sheet remains in negative equity from FY20 onwards. This option will still require significant injection of cash via PDC to return to a positive equity position.

8.2.3.4 HRI as the site for unplanned care

Under this option, all unplanned care is delivered at the Huddersfield Royal Infirmary site, with Calderdale Royal Hospital delivering planned care (see Section 8.1).

Initiative	Net savings HRI Unplanned Care (£m) (Real)	
Deliver best in class LOS, DNAs, New to FU ratios	1.9	
Address clinical variation	1.3	
Reconfiguration of hospital services	3.2	
Workforce and skills planning	5.5	
Optimise ambulatory care and community service models to reduce demand	1.2	Nominal value of savings (£m)
TOTAL	**13.1**	**14.7**

Table 40 –Savings arising from reconfiguring services using HRI as the site for unplanned care

The above table includes the lost contribution impact of activity going to other providers (£0.2m).

In addition to the £6.7m of real savings associated with the strategic initiatives, real revenue savings of £13.1m (£14.7m nominal) have been identified from reconfiguring services and using HRI as the unplanned site.

The I&E position under this option is improved by £9.6m (in nominal terms) compared with the Do Minimum option, from £31.2m to £21.6m. The savings shown above are offset by an increase in depreciation (£7.8m) and capital loan interest payments (£6.5m) as well as a reduction in PDC and working capital interest payments (£1.8m).

£m	FY17	FY18	FY19	FY20	FY21	FY22
Clinical Revenue	327.7	325.8	325.3	326.0	325.6	324.9
Non Protected/Non Mandatory Clinical Revenue	4.9	4.9	4.9	4.9	4.9	4.9
Other Revenue	28.6	32.9	32.9	32.9	32.9	32.9
Total Revenue	**361.2**	**363.6**	**363.1**	**363.8**	**363.4**	**362.6**
Employee Benefit Expenses	(241.7)	(235.5)	(228.5)	(222.5)	(218.5)	(210.0)
Drugs	(31.9)	(32.2)	(32.5)	(32.8)	(33.1)	(33.5)
Clinical Supplies & Services	(34.4)	(33.2)	(34.0)	(34.3)	(35.4)	(36.2)
Other Expenses	(48.2)	(46.4)	(45.4)	(44.7)	(44.0)	(46.1)
PFI Operating Expenses	(12.1)	(12.5)	(12.8)	(13.2)	(13.6)	(9.6)
Total Operating Expenditure	**(368.2)**	**(359.5)**	**(353.3)**	**(347.5)**	**(344.6)**	**(335.4)**
EBITDA	**(7.0)**	**4.1**	**9.8**	**16.3**	**18.8**	**27.2**
EBITDA Margin (%)	*-2.0%*	*1.0%*	*2.7%*	*4.5%*	*5.2%*	*7.5%*
Gain/(loss) on asset disposals	0.0	-	-	-	-	-
Impairment Losses (Reversals) net	-	-	-	(31.3)	-	-
Total Depreciation & Amortisation	(12.0)	(13.3)	(14.9)	(18.4)	(20.6)	(20.7)
Interest expense on overdrafts and working capital facilities	(0.5)	(2.2)	(3.1)	(4.1)	(5.3)	(6.4)
Total interest payable on Loans and leases	(12.2)	(13.8)	(17.0)	(18.8)	(18.7)	(18.4)
PDC Dividend	(4.0)	(4.2)	(4.0)	(3.5)	(3.1)	(3.3)
Total Non-Operating Expenses	**(28.8)**	**(33.6)**	**(39.0)**	**(76.1)**	**(47.7)**	**(48.9)**
Net Surplus / (Deficit)	**(35.8)**	**(29.5)**	**(29.2)**	**(59.8)**	**(29.0)**	**(21.6)**
Net Surplus / (Deficit) margin (%)	*-9.9%*	*-8.1%*	*-8.0%*	*-16.4%*	*-8.0%*	*-6.0%*
Normalised (excluding impairments / Disposals)	**(35.8)**	**(29.5)**	**(29.2)**	**(28.5)**	**(29.0)**	**(21.6)**

Table 41 - HRI as the site for unplanned care I&E forecast

Significant investment in estate above the identified backlog of maintenance for time expired buildings level is required to enable HRI to deliver unplanned services (see section 8.2.4). This amounts to an extra £208.7m of reconfiguration capital on top of the £92.4m backlog requirement. The resulting depreciation and interest charges partly offset the savings of the reconfiguration.

The improved I&E position results in an improvements to the balance sheet position, in particular to cash which is £16.8m higher in FY22 than the 'Do Nothing' option.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Property, Plant and Equipment	**282.9**	**371.6**	**455.7**	**484.3**	**476.0**	**467.4**
Inventories	6.1	6.1	6.1	6.1	6.1	6.1
NHS Trade Receivables	3.2	3.2	3.2	3.2	3.2	3.2
Non NHS Trade Receivables	2.3	2.3	2.3	2.3	2.3	2.3
Other Current Assets	10.8	10.8	10.8	10.8	10.8	10.8
Cash and Cash Equivalents	(49.2)	(79.2)	(102.9)	(136.5)	(172.1)	(200.2)
Current assets	(26.7)	(56.7)	(80.4)	(114.0)	(149.5)	(177.7)
Total assets	256.1	314.8	375.3	370.2	326.4	289.6
Current Liabilities	(40.7)	(39.4)	(51.3)	(51.4)	(51.7)	(51.6)
Non-Current Liabilities	(146.2)	(235.6)	(313.4)	(368.0)	(352.9)	(337.8)
Total Liabilities	(186.9)	(275.0)	(364.7)	(419.4)	(404.6)	(389.4)
Net assets employed	**69.3**	**39.8**	**10.6**	**(49.2)**	**(78.1)**	**(99.8)**
Public dividend capital	115.7	115.7	115.7	115.7	115.7	115.7
Retained Earnings (Accumulated Losses)	(82.5)	(112.0)	(141.2)	(200.9)	(229.9)	(251.5)
Donated asset reserve	-	-	-	-	-	-
Revaluation reserve	36.1	36.1	36.1	36.1	36.1	36.1
Miscellaneous reserves	-	-	-	-	-	-
Total taxpayers' equity	**69.3**	**39.8**	**10.6**	**(49.2)**	**(78.1)**	**(99.8)**

Table 42 - HRI as the site for unplanned care balance sheet forecast

The increased level of capital investment and associated loan financing required under this option worsens the net liability position, in comparison to the Do Minimum option, by FY22. The increased capital loan financing also results in an increased finance charge to the I&E (£6.5m) by FY22).

8.2.3.5 CRH as the site for unplanned care

Under this option, Calderdale Royal Hospital is used as the site for delivering unplanned care, with Huddersfield Royal Infirmary being retained to deliver planned services (see Section 8.1).

The savings derived from implementing the strategic initiatives once again still apply under this option. The Trust is also expected to deliver the savings identified in Table 36. Additional savings from the reconfiguration of services are detailed in Table 43.

Initiative	Net savings CRH Unplanned Care (£m) (Real)	
Deliver best in class LOS, DNAs, New to FU ratios	1.9	
Address clinical variation	1.3	
Reconfiguration of hospital services	6.1	
Workforce and skills planning	5.5	
Optimise ambulatory care and community service models to reduce demand	1.2	Nominal value of savings (£m)
TOTAL	**16.0**	**18.0**

Table 43 - Savings arising from reconfiguring services using CRH as the site for unplanned care

The above table includes the contribution impact of activity going to other providers (£0.4m).

Under this option, less investment in backlog is required (£15.5m vs £92.4m) as the main HRI site will not be fully utilised post year 5. A higher level of reconfiguration savings can be realised (£18.0m vs £14.7m in nominal terms) as a result of reduced operating costs associated with the new build at Acre Mills.

The I&E position under this option is improved by £21.7m (in nominal terms) compared with the Do Minimum option, from £31.2m to £9.5m. The savings shown above are offset by an increase in depreciation (£3.0m) and capital loan interest payments (£6.3m) as well as a reduction in PDC and working capital interest payments (£5.6m). There is a greater level of savings associated with PDC and depreciation as a result of the disposal of the main HRI site in FY21.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Clinical Revenue	327.7	325.8	325.3	326.0	325.6	324.9
Non Protected/Non Mandatory Clinical Revenue	4.9	4.9	4.9	4.9	4.9	4.9
Other Revenue	28.6	32.9	32.9	32.9	32.9	32.9
Total Revenue	**361.2**	**363.6**	**363.1**	**363.8**	**363.4**	**362.6**
Employee Benefit Expenses	(241.7)	(235.3)	(228.5)	(222.5)	(218.5)	(207.6)
Drugs	(31.9)	(32.2)	(32.5)	(32.8)	(33.1)	(33.5)
Clinical Supplies & Services	(34.4)	(33.2)	(34.0)	(34.3)	(35.4)	(36.2)
Other Expenses	(48.2)	(46.4)	(45.4)	(44.7)	(44.0)	(41.0)
PFI Operating Expenses	(12.1)	(12.5)	(12.8)	(13.2)	(13.6)	(14.0)
Total Operating Expenditure	**(368.2)**	**(359.5)**	**(353.3)**	**(347.5)**	**(344.6)**	**(332.2)**
EBITDA	**(7.0)**	**4.1**	**9.8**	**16.3**	**18.8**	**30.4**
EBITDA Margin (%)	*-2.0%*	*1.1%*	*2.7%*	*4.5%*	*5.2%*	*8.4%*
Gain/(loss) on asset disposals	0.0	-	-	-	(58.3)	-
Impairment Losses (Reversals) net	-	-	-	(41.4)	-	-
Total Depreciation & Amortisation	(15.7)	(19.7)	(17.0)	(16.0)	(15.9)	(15.9)
Interest expense on overdrafts and working capital facilities	(0.5)	(2.2)	(3.1)	(4.0)	(5.0)	(5.8)
Total interest payable on Loans and leases	(11.8)	(13.1)	(16.2)	(18.6)	(18.4)	(18.2)
PDC Dividend	(4.0)	(3.9)	(3.6)	(2.9)	(1.0)	-
Total Non-operating Expenses	**(32.0)**	**(38.9)**	**(39.9)**	**(82.9)**	**(98.7)**	**(39.9)**
Net Surplus / (Deficit)	**(39.0)**	**(34.8)**	**(30.1)**	**(66.5)**	**(79.9)**	**(9.5)**
Net Surplus / (Deficit) margin (%)	*-10.8%*	*-9.6%*	*-8.3%*	*-18.3%*	*-22.0%*	*-2.6%*
Normalised (excluding impairments / Disposals)	**(39.0)**	**(34.8)**	**(30.1)**	**(25.2)**	**(21.6)**	**(9.5)**

Table 44 - CRH as the site for unplanned care I&E forecast

Significant investment in estate above the identified backlog level is required to enable HRI to deliver unplanned services (see section 8.2.4). This amounts to an extra £275.7m of reconfiguration capital as well as a £15.5m backlog requirement. The resulting depreciation and interest charges partly offset the savings of the reconfiguration.

The improved I&E position results in an improvements to the balance sheet position, in particular to cash which is £38.4m higher in FY22 than the 'Do Nothing' option.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Property, Plant and Equipment	**248.6**	**330.1**	**411.4**	**454.6**	**367.8**	**363.9**
Inventories	6.1	6.1	6.1	6.1	6.1	6.1
NHS Trade Receivables	3.2	3.2	3.2	3.2	3.2	3.2
Non NHS Trade Receivables	2.3	2.3	2.3	2.3	2.3	2.3
Other Current Assets	10.8	10.8	10.8	10.8	10.8	10.8
Cash and Cash Equivalents	(48.7)	(77.7)	(100.2)	(132.6)	(158.1)	(178.6)
Current assets	**(26.3)**	**(55.3)**	**(77.7)**	**(110.0)**	**(135.6)**	**(156.1)**
Total assets	**222.3**	**274.9**	**333.7**	**344.6**	**232.2**	**207.9**
Current Liabilities	**(40.7)**	**(39.4)**	**(50.9)**	**(51.0)**	**(51.3)**	**(51.1)**
Non-Current Liabilities	**(115.5)**	**(204.1)**	**(281.5)**	**(358.9)**	**(344.2)**	**(329.5)**
Total Liabilities	**(156.2)**	**(243.6)**	**(332.5)**	**(409.9)**	**(395.5)**	**(380.6)**
Net assets employed	**66.1**	**31.3**	**1.2**	**(65.3)**	**(163.2)**	**(172.8)**
Public dividend capital	115.7	115.7	115.7	115.7	115.7	115.7
Retained Earnings (Accumulated Losses)	(85.7)	(120.5)	(150.5)	(217.1)	(297.0)	(306.5)
Donated asset reserve	-	-	-	-	-	-
Revaluation reserve	36.1	36.1	36.1	36.1	18.1	18.1
Miscellaneous reserves	-	-	-	-	-	-
Total taxpayers' equity	**66.1**	**31.3**	**1.2**	**(65.3)**	**(163.2)**	**(172.8)**

Table 45 - CRH as the site for unplanned care balance sheet forecast

The increased level of capital investment and associated loan financing required under this option worsens the net liability position, in comparison to the Do Minimum option, by FY22. The increased capital loan financing also results in an increased finance charge to the I&E (£6.3m by FY22).

However, the cash position under this option is £21.6m more favourable than under the HRI site being the base for unplanned care option. This is due to the level of cash releasing revenue savings generated by this reconfiguration operation being the highest out of all of the options, with the peak deficits being driven by non-cash accounting adjustments related to asset disposals or impairments.

8.2.4 Capital expenditure under each option

Each option, including the Do Nothing option, requires CHFT to make significant capital outlays. The level of backlog of maintenance for time expired buildings required at HRI (£92.4m), coupled with any capital expenditure for reconfiguration works has a significant bearing on the financial forecasts of each option.

This section presents the capital outlays required, broken down by backlog and reconfiguration works and detailing the cash and revenue impacts of these.

8.2.4.1 Do Nothing and Strategic Initiative Savings only options

Under the Do Nothing option and Strategic Initiatives only option, there is no reconfiguration spend. The required capital expenditure, therefore, relates to the £92.4m of backlog of maintenance for time expired buildings required, primarily at HRI.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Maintenance and upgrade capital	(18.5)	(18.5)	(18.5)	(18.5)	(18.5)	-
Cumulative capital	(18.5)	(37.0)	(55.4)	(73.9)	(92.4)	(92.4)
Impairment	-	-	-	-	-	-
Cumulative loan draw down	18.5	37.0	55.4	73.9	92.4	92.4
Loan repayments	-	-	-	(3.7)	(3.7)	(3.7)
Loan interest	(0.2)	(0.7)	(1.3)	(1.7)	(2.1)	(2.0)
Depreciation	(0.6)	(1.2)	(1.8)	(2.5)	(3.1)	(3.1)
Cumulative cash impact	**(19.1)**					
Cumulative I&E impact	**(20.3)**					

Table 46 - Cash and I&E implications of options with no reconfiguration

8.2.4.2 HRI as the site for unplanned care

Under the option with HRI as the site for unplanned care, the £92.4m of backlog of maintenance for time expired buildings is still required, plus an additional £208.7m of reconfiguration capital across both sites.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Maintenance and upgrade capital	*(46.2)*	*(23.1)*	*(23.1)*	-	-	-
Reconfiguration capital spend	-	*(69.6)*	*(69.6)*	*(69.6)*	-	-
Total capital spend	**(46.2)**	**(92.7)**	**(92.7)**	**(69.6)**	**-**	**-**
Cumulative capital spend	**(46.2)**	**(138.9)**	**(231.5)**	**(301.1)**	**(301.1)**	**(301.1)**
Impairment	-	-	(31.3)	(31.3)	(31.3)	(31.3)
Cumulative loan draw down	(46.2)	(138.9)	(262.8)	(332.4)	(332.4)	(332.4)
Loan repayments	46.2	138.9	231.5	301.1	301.1	301.1
Loan interest	-	-	-	(12.0)	(12.0)	(12.0)
Depreciation	(0.6)	(2.3)	(5.4)	(7.1)	(6.8)	(6.5)
Cumulative cash impact	**(92.1)**					
Cumulative I&E impact	**(87.2)**					

Table 47 - Cash and I&E implications of HRI as the site for unplanned care

8.2.4.3 CRH as the site for unplanned care

If CRH is chosen as the site for the provision of unplanned care, the level of backlog maintenance expenditure is much reduced. This is because there would be more reconfiguration expenditure at

the HRI site to create space for elective services. The higher level of capital expenditure on new works attracts a higher impairment charge to the I&E than if HRI was the site providing unplanned care.

There will be minimal backlog of maintenance for time expired buildings to maintain existing buildings at HRI for five years, until they can be disposed of. It is this disposal that drives the deficit higher in FY20, as the anticipated proceeds from the sale of HRI assets is £7.0m against a net book value of £83.3m. The revaluation reserve can be used to partly offset this impact by £18.0m.

£m	FY17	FY18	FY19	FY20	FY21	FY22
Backlog capital spend	*(15.5)*	-	-	-	-	-
Reconfiguration capital spend	-	*(91.9)*	*(91.9)*	*(91.9)*	-	-
Total capital spend	**(15.5)**	**(91.9)**	**(91.9)**	**(91.9)**	**-**	**-**
Cumulative capital spend	**(15.5)**	**(107.4)**	**(199.3)**	**(291.2)**	**(291.2)**	**(291.2)**
Impairment	-	-	-	(41.4)	(41.4)	(41.4)
Cumulative loan draw down	15.5	107.4	199.3	291.2	291.2	291.2
Loan repayments	-	-	-	(11.6)	(11.6)	(11.6)
Loan interest	(0.2)	(1.5)	(4.7)	(6.8)	(6.6)	(6.3)
Proceeds of HRI sale	-	-	-	-	*7.0*	-
Net book value of HRI assets	-	-	-	-	*83.3*	-
HRI revaluation reserve	-	-	-	-	*18.0*	-
Loss on sale of HRI	-	-	-	-	(58.3)	-
Capital spend depreciation	*(5.2)*	*(5.2)*	*(5.2)*	*(2.9)*	*(5.9)*	*(5.9)*
Depreciation impact of HRI sale	-	-	-	-	*3.1*	*(3.1)*
Revised depreciation	(5.2)	(5.2)	(5.2)	(2.9)	(2.8)	(9.0)
Cumulative cash impact	**(92.1)**					
Cumulative I&E impact	**(87.2)**					

Table 48 - Cash and I&E implications of CRH as the site for unplanned care

8.2.5 Funding requirements for each option

This section presents the required level of funding for each option, broken down by source. A summary of the funding requirement by source is presented in Table 49 below.

£m	ITFF Loan	Cash / PDC	Commissioners / NHS England	Total funding requirement
Do Nothing	81.3	135.8	-	**217.0**
Strategic initiative savings only	156.0	124.4	-	**280.4**
HRI as the site for unplanned care	364.7	136.6	7.8	**509.1**
CRH as the site for unplanned care	354.8	115.0	9.1	**478.8**

Table 49 - Summary of funding requirement under each option

Whilst the Do Nothing option requires the least amount of external funding over the six years to FY22, the financial forecasts show this option to have the worst recurrent deficit position by FY22.

Therefore, the level of Cash/PDC support required beyond FY22 would be expected to be higher than the other options.

On the basis that the Do Nothing option represents the least financially sustainable option (i.e. the greatest recurrent deficit in FY22 of £31.2m) and does not provide clinical sustainability (See Section 8.1), this is the least attractive of all options.

Delivering strategic savings, without reconfiguration of services, results in an improved deficit position by FY22 to a deficit of £27.5m. However, the Trust's debt requirement increases compared to the Do Nothing option as a result of resolving backlog of maintenance for time expired buildings requirements.

The reconfiguration of services, with either HRI or CRH being the site for unplanned care, results in a further improvement to the deficit position by FY22 (Deficit of £21.0m and £9.5m respectively). However, the Trust's debt requirement further increases compared to the Do Nothing option as a result of resolving backlog of maintenance for time expired buildings requirements and increasing capacity at either of the sites.

The capital outlays associated with either of the reconfiguration options are significant, especially when compared with the Do Nothing option. However, the Capital Plan (see Section 8.3) clearly demonstrates that renovation of the Trust's hospitals is required to be able to deliver the services within the proposed configuration.

The improved recurrent financial position from FY22 when CRH is the site delivering unplanned care (£9.5m deficit compared to £31.2m deficit under Do Nothing), as well as the improved cash deficit position (£178.6m deficit compared to £217.0m under Do Nothing) makes this the preferred financial option.

8.2.6 Sensitivity analysis

The Trust has undertaken sensitivity analysis on the financials relating to the proposed CRH unplanned care site reconfiguration option, which is described in the Five Year Strategic Plan.

A series of sensitivity factors were identified, quantified and applied to the CRH option financials - the implications of these on the Trust's deficit and cash positions are summarised in the following 'Downside Sensitivities' and 'Upside Sensitivities' sections.

The following table highlights the bottom line deficit projections for the CRH unplanned care site option, as identified in the Five Year Strategic Plan. In the table below, the following non recurrent items have then been stripped out of these deficits to show the underlying (recurrent) deficit positions in each year.

- Impairments of £41.4m in FY20
- A loss on disposal of £58.3m in FY21

Table 50: Underlying deficit for the CRH unplanned care site option

Deficit £'m	FY17	FY18	FY19	FY20	FY21	FY22
Bottom line CRH option	**(39.0)**	**(34.8)**	**(30.1)**	**(66.5)**	**(79.9)**	**(9.5)**
Impairments	-	-	-	41.4	-	-
HRI loss on disposal	-	-	-	-	58.3	-
Underlying CRH option	**(39.0)**	**(34.8)**	**(30.1)**	**(25.2)**	**(21.6)**	**(9.5)**

The downside and upside sensitivities bridge from the underlying financials are indicated above.

8.2.6.1 Downside sensitivities

The following downside scenarios have been considered by the Trust:

- **Marginal cost of Commissioner QIPP** – the Five Year Strategic Plan assumes that the £12.4m loss of income relating to Commissioner QIPP can be matched with fully with a reduction in cost. This sensitivity reflects the risk that only 75% of the cost reduction is achievable, retaining 25% of this cost. This worsens the deficit by £3.7m by FY22.
- **Additional Commissioner QIPP** – Commissioners' QIPP submissions to the Trust included £14.6m greater reductions in income for CHFT by FY22 than the Trust have included in the Five Year Strategic Plan. This sensitivity highlights the impact of this additional £14.6m income reduction for the Trust, at 75% marginal cost. This worsens the deficit by £2.0m by FY22.
- **Under delivery of strategic savings** – this sensitivity captures the impact of a 20% under delivery in the proposed (non-reconfiguration related) strategic savings identified in the Five Year Strategic Plan. This worsens the deficit by £0.6m by FY22.
- **Under delivery of reconfiguration savings** – this sensitivity captures the impact of a 20% under delivery in the proposed reconfiguration savings identified in the Five Year Strategic Plan. This worsens the deficit by £3.3m by FY22.
- **Under delivery of EPR savings** – this sensitivity captures the impact of a 50% under delivery in the proposed EPR savings identified in the Five Year Strategic Plan. This worsens the deficit by £2.1m by FY22.
- **Further EPR activity / income loss** – the Trust's FY17 plan includes a £5.0m non recurrent risk to activity and income levels over a three month period resulting from the disruption caused by the EPR implementation. This sensitivity captures the impact of a 50% increase on this potential non-recurrent activity and income loss.

The following table highlights the overall impact of the above downside sensitivities on the underlying deficit, increasing it by £11.9m from £9.5 to £21.4m in FY22.

	Net surplus / (deficit) £m					
	FY17	FY18	FY19	FY20	FY21	FY22
Underlying CRH option	**(39.0)**	**(34.8)**	**(30.1)**	**(66.5)**	**(79.9)**	**(9.5)**
QIPP 25% retained costs	-	(0.8)	(1.4)	(2.2)	(2.9)	(3.7)
QIPP £14.6m extra at 75%	-	(0.7)	(1.1)	(1.5)	(1.8)	(2.0)
Strategic savings - 20%	-	(0.2)	(0.4)	(0.6)	(0.6)	(0.6)
Reconfiguration savings - 20%	-	(0.3)	(0.7)	(1.1)	(1.5)	(3.3)
EPR savings - 50%	-	(0.6)	(1.5)	(1.9)	(2.0)	(2.1)
EPR activity loss	(2.5)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)
Sub - total movement	**(2.5)**	**(2.8)**	**(5.2)**	**(7.4)**	**(8.9)**	**(11.9)**
Downside case	**(41.5)**	**(37.6)**	**(35.3)**	**(73.9)**	**(88.8)**	**(21.4)**

Table 51: The impact of downside sensitivities on the Trust's underlying surplus / (deficit) position

The following table highlights the impact of these downside sensitivities on the Trust's cash balance, increasing the shortfall in cash by £38.6m from a shortfall of £178.6m to a shortfall of £217.2m by FY22.

	Cash £m					
	FY17	FY18	FY19	FY20	FY21	FY22
Underlying CRH option	**(48.7)**	**(77.7)**	**(100.2)**	**(132.6)**	**(158.1)**	**(178.6)**
QIPP 25% marginal cost	-	(0.8)	(2.3)	(4.4)	(7.3)	(11.0)
QIPP £14.6 extra at 75%	-	(0.7)	(1.7)	(3.2)	(5.0)	(6.9)
Strategic savings - 20%	-	(0.2)	(0.6)	(1.1)	(1.7)	(2.3)
Reconfiguration savings - 20%	-	(0.3)	(1.0)	(2.2)	(3.6)	(7.0)
EPR savings - 50%	-	(0.6)	(2.1)	(4.1)	(6.1)	(8.2)
EPR activity loss	(2.5)	(2.7)	(2.8)	(2.9)	(3.0)	(3.1)
Sub - total movement	**(2.5)**	**(5.3)**	**(10.4)**	**(17.9)**	**(26.7)**	**(38.6)**
Downside case	**(51.2)**	**(83.0)**	**(110.6)**	**(150.5)**	**(184.8)**	**(217.2)**

Table 52: The impact of downside sensitivities on the Trust's cash balances / (shortfalls)

8.2.6.2 Upside sensitivities

The following upside scenarios have been considered by the Trust:

- **Enhanced CIP delivery** – this upside reflects the impact of increasing the Trust's annual CIP delivery by 0.5% (of total income), which reduces the deficit position by £12.8m by FY22.
- **Increasing the value of HRI land sale** – this upside reflects the potential for achieving higher proceeds for the proposed sale of the HRI site, increasing proceeds by 50% from £7.0m to £10.5m. This reduces the deficit position by £0.1m by FY21.
- **Increased margin from commercial ventures** – this upside reflects the potential for the Trust to further benefit from increased income and margin associated with a number of commercial ventures (such as the Pharmacy Manufacturing Unit and Health Informatics Service). This reduces the deficit by £2.2m by FY22.
- **Cost savings associated with back office partnerships** – this upside reflects the scope for the Trust partnering with other organisations to explore different models for providing back office services (such as shared services or outsourcing). This reduces the deficit by £2.2m by FY22.

The following table highlights the overall impact of the above upside sensitivities on the underlying financial position, improving it by £17.3m from a deficit of £9.5m to surplus of £7.8m in FY22.

	Net surplus / (deficit) £m					
	FY17	FY18	FY19	FY20	FY21	FY22
Underlying CRH option	(39.0)	(34.8)	(30.1)	(66.5)	(79.9)	(9.5)
CIP delivery	1.8	3.6	5.8	7.9	10.3	12.8
Land sale proceeds	0	0	0	0	3.6	0.1
Commercial ventures	0	0.5	1	1.6	2.1	2.2
Back office partnerships	0	0.4	1	1.6	2.1	2.2
Sub - total movement	1.8	4.6	7.8	11.1	18.1	17.3
Upside case	(37.2)	(30.2)	(22.3)	(55.4)	(61.8)	**7.8**

Table 53: The impact of upside sensitivities on the Trust's underlying surplus / (deficit) position

The following table highlights the impact of these upside sensitivities on the Trust's cash balance, reducing the shortfall in cash by £60.4m from a shortfall of £178.6m to a shortfall of £118.2m by FY22.

	Cash £m					
	FY17	FY18	FY19	FY20	FY21	FY22
Underlying CRH option	**(48.7)**	**(77.7)**	**(100.2)**	**(132.6)**	**(158.1)**	**(178.6)**
CIP delivery	1.8	5.4	11.2	19.1	29.4	42.2
Land sale proceeds	0.0	0.0	0.0	0.0	3.6	3.7
Commercial ventures	0.0	0.5	1.5	3.0	5.1	7.3
Back office partnerships	0.0	0.4	1.4	2.9	5.0	7.2
Sub - total movement	**1.8**	**6.3**	**14.1**	**25.1**	**43.1**	**60.4**
Upside case	**(46.9)**	**(71.4)**	**(86.1)**	**(107.5)**	**(115.0)**	**(118.2)**

Table 54: The impact of downside sensitivities on the Trust's cash balances / (shortfalls)

8.2.7 Conclusions to the Financial Case

The preferred financial option is that unplanned care services be delivered from the CRH site, with HRI delivering planned care. This is the option that results in the most favourable I&E position by FY22, as well as the most favourable cash position.

Table 55: I&E impact of each option compared with the Do Nothing option

and Table 56 below compares the I&E and cash impacts of the three options against the Do Nothing option. Further details are provided in the Appendix, in Section 10.1:

£m	FY16	FY17	FY18	FY19	FY20	FY21	FY22
Do Nothing	-	-	-	-	-	-	-
Strategic Initiatives Only	-	(1.6)	(0.6)	1.1	3.9	3.3	3.7
HRI as site for unplanned care	-	(2.8)	(2.0)	(0.7)	(29.4)	1.9	9.6
CRH as site for unplanned care	-	(6.0)	(7.3)	(1.6)	(36.2)	(49.1)	21.7

Table 55: I&E impact of each option compared with the Do Nothing option

Table 55 demonstrates the significant positive impact that utilising CRH as the site for unplanned care has on the I&E position of the Trust. Between FY17 and FY19, this option has the highest deficit position as a result of backlog maintenance being depreciated over a shorter period. FY20 includes an impairment of £41.4m and FY21 includes a loss on disposal of £58.3m. These are non-recurrent impacts on the underlying position.

The table below shows the specific factors that result in improvements to the deficit position, against the Do Nothing option, in FY22.

£m (Nominal)	Strategic initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
FY22 Do Nothing Surplus/ (Deficit)	**(31.2)**	**(31.2)**	**(31.2)**
Depreciation	(3.3)	(7.8)	(3.0)
Capital Loan Interest	(2.0)	(6.5)	(6.3)
PDC	0.7	1.5	4.8
Working capital interest	0.9	0.3	0.8
Strategic savings	7.4	7.4	7.4
Reconfiguration savings	—	14.7	18.0
FY22 Surplus / (Deficit)	**(27.5)**	**(21.6)**	**(9.5)**

Table 56: Bridge from Do Nothing to each of the options

Table 57 below shows the improvements to the EBITDA position against the Do Nothing option.

£m	FY16	FY17	FY18	FY19	FY20	FY21	FY22
Do Nothing	—	—	—	—	—	—	—
Strategic Initiatives Only	—	—	1.1	3.6	7.0	7.1	7.4
HRI as site for unplanned care	—	—	2.3	7.1	12.7	14.3	21.8
CRH as site for unplanned care	—	—	2.3	7.1	12.7	14.3	25.0

Table 57: EBITDA impact of each option compared with the Do Nothing option

Table 58: Cash impact of each option compared with the Do Nothing option

shows that the CRH as the unplanned care site delivers the most preferable cash position.

£m	FY16	FY17	FY18	FY19	FY20	FY21	FY22
Do Nothing	—	—	—	—	—	—	—
Strategic Initiatives Only	—	(1.0)	4.3	13.9	23.2	25.7	29.0
HRI as site for unplanned care	—	(1.3)	3.8	12.7	14.5	11.7	16.8
CRH as site for unplanned care	—	(0.8)	5.2	15.4	18.4	25.7	38.4

Table 58: Cash impact of each option compared with the Do Nothing option

The two options that result in the most improved deficit position are HRI as the site for unplanned care and CRH as the site for unplanned care. Although the Clinical Model is the same under each option, there are site specific differences that results in differing deficits. The following table bridges the FY22 deficit and EBITDA positions between HRI as the site for unplanned care and CRH as the site for unplanned care.

£m	FY22 EBITDA	FY22 I&E	Description
HRI as site for unplanned care	**27.2**	**(21.6)**	
Depreciation	-	4.8	Reduction in depreciation as a result of disposal of the HRI main site (£3.1m), reduced backlog of maintenance for time expired buildings capital requirement (£3.1m). This is offset by an increase in reconfiguration capital (£1.4m).
Site reconfiguration - Site operating costs	3.3	3.3	Lower estates lifecycle costs (facilities management, utilities etc.) arising from the new build configuration and the ability of the Trust to reduces equivalent costs at downsized / closed sites
Capital loan interest	-	0.2	CRH as the site for unplanned care requires a backlog / reconfiguration capital loan of £9.9m less and as such, the interest payments are lower
PDC dividend	-	3.3	PDC payments are based on the net relevant asset position of the balance sheet. The asset disposal and the reduced capital expenditure reduces the net relevant asset position and therefore the PDC. No cash funding is required to realise this benefit.
Working capital interest	-	0.5	A reduced cash deficit results in a lower interest payment on overdrafts
CRH as site for unplanned care	**30.4**	**(9.5)**	

Table 59: I&E and EBITDA differences between HRI as site for unplanned care and CRH as site for unplanned care

The £3.3m difference in estates and facilities lifecycle costs (facilities management, utilities etc.) is broken down in the table below (analysing the 'real' value of £2.9m), and is driven firstly by the incremental costs of the new build and secondly by the savings associated with reducing capacity at the planned care site.

Cost £m (real)	HRI unplanned care site option	CRH unplanned care site option	Difference
Annual maintenance	1.1	1.9	0.7
Operational cost (cleaning, catering, admin etc.)	3.8	5.0	1.2
Intermittent maintenance costs (annualised)	0.1	0.1	-
Incremental costs at the unplanned care site	**5.0**	**6.9**	**1.9**
Incremental savings at the planned care site	**(4.6)**	**(9.4)**	**(4.8)**
Net increase / (decrease)	**0.4**	**(2.5)**	**(2.9)**

Table 60: Facilities costs and savings

Under the HRI unplanned care site option, the capital build at HRI results in incremental estates and facilities operating costs of £5.0m per annum, relating to annual maintenance costs of £1.1m,

operational costs (cleaning, catering, admin) of £3.8m and intermittent maintenance costs (annualised) of £0.1. These costs are offset by £4.6m cost savings at CRH relating to PFI facilities management costs (50% of current CRH soft facilities management costs) and PFI utility costs (33% of CRH electricity, gas and water). Overall this yields a net £0.4m increase in costs.

Under the CRH unplanned care site option, the capital build at CRH results in incremental estates and facilities operating costs of £6.9m per annum, relating to annual maintenance costs of £1.9m, operational costs (cleaning, catering, admin) of £5.0m and intermittent maintenance costs (annualised) of £0.1. These costs are offset by savings of £9.4m in estates and facilities operating costs at HRI, yielding a net reduction in costs of £2.5m.

Whilst the CRH unplanned care site option yields greater incremental costs of £1.9m for the capital build, the estimated savings associated with the planned site reduction are £4.8m greater owing to the restrictions around PFI arrangements. This results in the difference of £2.9m (or £3.3m nominal) between the two options.

The figures in the table were obtained from a Lendlease 'Life Cycle Costing CHFT Cost Model' report, detailing lifecycle costs under the various options being considered by the Trust. The exceptions to this are the reductions in PFI related costs at CRH of £4.6m, which were informed by Trust estates personnel.

No further assumptions have been made with regards to the PFI asset or contract treatment. The options around accounting treatment of the PFI contract could potentially be explored in the future in light of the proposed use of the CRH site.

One such consideration raised relates to the potential to treat the PFI as an onerous lease. Such a change would require sign off by DH, Monitor and the Trust's external auditors. The cash obligations to the PFI provider associated with financing the PFI would be unaffected and the cash liability would still need to be met.

The improved recurrent financial position from FY22 when CRH is the site delivering unplanned care (£9.5m deficit compared to £31.2m deficit under Do Nothing), as well as the improved cash deficit position (£178.6m deficit compared to £217.0m under Do Nothing) results in this option being the preferred option from a financial perspective.

8.3 Capital plan

Capital expenditure requirements ranging from £156.0m to £364.7m have been identified over the period to FY22 to support the 5 year plan.

- The size of the capital requirement is driven by three factors:
  - **The condition of the current estate at HRI**. HRI is 50 years old and requires extensive maintenance and upgrade. This is impacting patient care as there are issues with space and the age and fabric of the building. Further deferral of these costs is not considered feasible.
  - **Capital for the wider capital plan**, covering IMT infrastructure, replacement of equipment and capital to undertake essential works and maintenance.
  - **The need for capital to develop the estate to support proposed changes to the clinical model**.
- **Retaining services within the current configuration and within the current estate would require a total capital investment of £156.0m**
  - £92.4m to upgrade time expired buildings on the HRI site.
  - £62.4m for the wider capital plan, including IMT and equipment.
  - £1.2m to support the development of the Pharmacy Manufacturing Unit (PMU) which will in turn deliver £1.0m-£1.5m of strategic savings.
- **HRI as a site for unplanned care with CRH offering planned care would require a total capital investment of £364.7m.**
  - £92.4m to upgrade time expired buildings on the HRI site.
  - £63.6m for the wider capital plan, including IMT and Pharmacy Manufacturing Unit investment.
  - £208.7m for the development of the HRI site to accommodate the unplanned care facility.
- **CRH as a site for unplanned care with a new build at HRI or Acre Mills offering planned care would require a total capital investment of £354.8m.**
  - £15.5m to clear backlog maintenance (this is significantly reduced, as some, or all, of the main HRI site is disposed of in this option)
  - £63.6m for the wider capital plan, including IMT and Pharmacy Manufacturing Unit investment
  - £275.7m for the development of the CRH site to accommodate the unplanned care facility
  - Note: this option includes a net £7m capital receipt for the sale of the main HRI site

8.3.1.1 Introduction

This section sets out the Trust's expected capital expenditure and funding requirement between FY17 to FY22. This includes:

- The Trust's Estate
  - Background

- Upgrade of time expired buildings at the HRI site

- Capital expenditure required under each option
  - Other capital expenditure
  - Costs and implications for either HRI or CRH as the unplanned care site with the other being the planned care site
  - Impact on backlog of maintenance for time expired buildings at the HRI site

8.3.1.2 The Trust's Estate

The Trust is a large multi-site organisation, which since 2002, has comprised of two separate main campuses containing clinical and non-clinical accommodation which varies considerably in terms of type, age and quality. It provides services from a number of buildings across the geographical areas of Huddersfield & Halifax. The main service hub locations are shown in figure below:

Figure 36: Sites from which the Trust currently provide services

Acute services are provided from two hospitals, Huddersfield Royal Infirmary (HRI) in Huddersfield and Calderdale Royal Hospital (CRH) in Halifax. The Trust with development partners Henry Boot undertook the development of Acre Mills post attaining Foundation Trust status in 2006. Acre Mills was opened as an outpatient centre in 2015.

8.3.1.3 Calderdale Royal Infirmary

A map of the Calderdale Royal Infirmary site is included below:

Figure 37: CRH site

Calderdale Royal Hospital has a gross floor area of 59,817m^2 across a site with land area of 7.36 acres.

CRH is based in close proximity to Halifax town centre and opened in 2001. The hospital offers a full range of outpatient facilities as well as inpatient areas including Surgical, Medical, Maternity, ICU, Coronary Care and Children's wards. CRH has c450 beds and 9 theatres including 8 main theatres and an emergency Obstetrics theatre.

The Dales Unit on the Calderdale Royal Hospital site is occupied by South West Yorkshire Partnership Foundation Trust and includes three in-patient wards as well as a number of outpatient services.

The site was one of the first hospitals built through Private Finance Initiatives (PFI). The PFI arrangement runs until 2061 having been entered into over a 60 year term with a break clause after 30 years.

In 1998 the agreement to build a Private Finance Initiative (PFI) funded hospital in Calderdale was signed. Work commenced in January 1999 and the building was handed over to the Trust in March 2001. Parts of the old Halifax General Hospital buildings were retained and refurbished and in general these are used for office accommodation.

The hospital was built by the Catalyst Healthcare consortium, which then comprised the Lend Lease Corporation, Bovis Lend Lease Limited, ISS Mediclean Limited, the British Linen Bank Limited and the French bank Societe Generale. Bovis Lend Lease provided the design and construction services.

As part of the PFI agreement the Special Purpose Company (SPC) has agreements in place with Cofely for Estates Maintenance, Life Cycle and variation work and with ISS for the provision of Catering, Cleaning, Portering, Security, Car Park Management, Switchboard and Linen Distribution. The Trust works closely with all parties to ensure close and open partnership working.

In 2005 the car parking facility was extended to include the South Car Park and barrier car parking was introduced to try to assist with access to the hospital for patients and visitors.

In 2010 a new Endoscopy Unit was completed. 2012 saw the development of a new Angio Suite incorporating state of the art Catheter Lab at Calderdale and 2013 saw the installation of a new CT Scanner. In 2014 a new Coronary Care Advanced Pacing Theatre opened and in 2015 the Child Development Unit was completely refurbished to allow the merger of the services at Huddersfield and Calderdale.

Through the Cofely life cycle programme new chiller units were installed in the roof plant area in 2009 bringing improved efficiency and noise management by modern pump technology and controls. In the last 5 years Theatre operating lights, Passenger Lift cars, CCTV, Security Access systems, Fire detection, Doors & Windows have all received replacement and upgrade through Planned Life Cycle investment. The whole site is subject to planned replacement of flooring, fitted furniture and redecoration, NHS Estates Code condition B is confirmed through 3rd party surveys and routine audit.

In January 2016 Cofely will begin a Medical Gas Plant replacement program which will see the upgrade of 4Bar medical Air, 7Bar Surgical Air and Vacuum plant bringing new equipment and increased resilience to the site. Additionally 2016 will bring the upgrade and replacement of Critical Ventilation Systems incorporating requirements of the most recent Healthcare technical guidance.

The revenue costs of the site include interest and hard and soft facilities management. The total revenue cost for FY17 is expected to be c£23m. The backlog maintenance is managed through the PFI contract and supported by regular capital lifecycle payments into the PFI provider.

8.3.1.3.1 Backlog maintenance

Building maintenance is managed through the SPC and funded through regular planned lifecycle payments. There is no backlog maintenance of note and the building is compliant to NHS Estates Code condition B.

8.3.1.4 Huddersfield Royal Infirmary

A map of the Huddersfield Royal Infirmary site is included below:

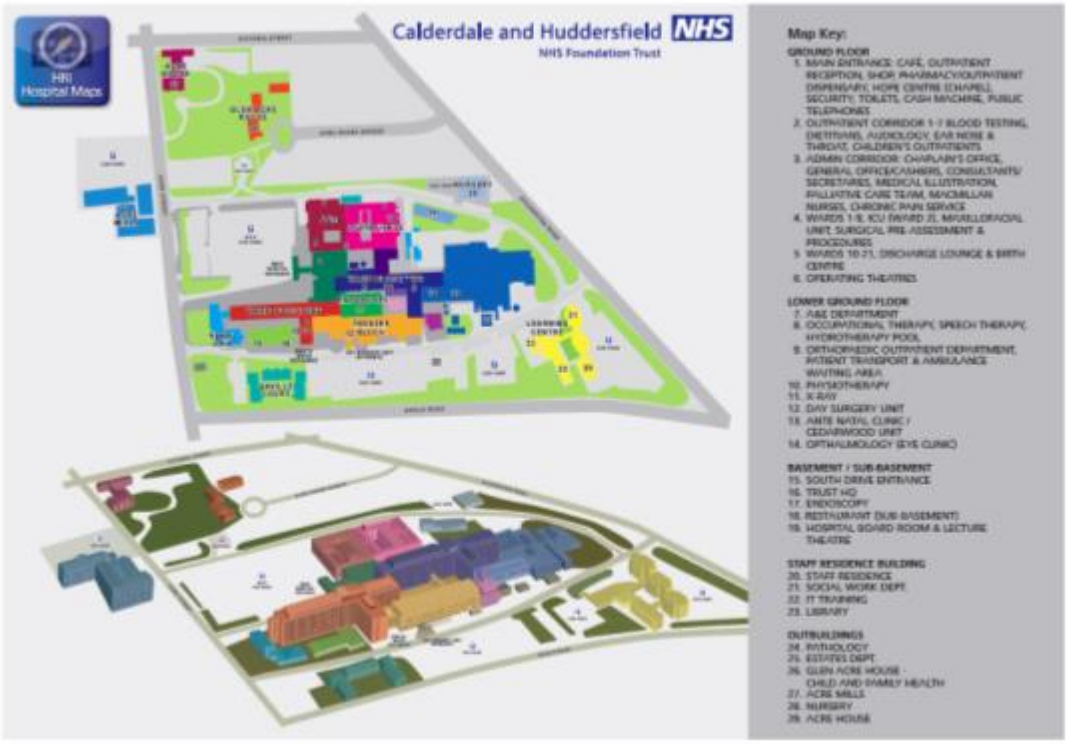


Figure 38: HRI site

Huddersfield Royal Infirmary has a gross floor area of 67,493m^2 across a site with land area of 16.77 acres.

Huddersfield Royal Infirmary is about three miles from Huddersfield town centre. The main hospital first opened its doors in 1965 and since then many millions have been invested in the site to modernise and extend it.

The hospital offers a full range of day case and outpatient services and an accident and emergency department. It is also the specialist centre for emergency surgery, planned complex surgery and emergency paediatric surgery for the people of Huddersfield and Calderdale.

Recent major developments have included the opening of a £3.4 million urology unit and investment in a £500,000 state-of-the-art CT (computerised tomography) scanner and suite.

Early in 2008 the new Huddersfield Family Birth Centre opened at the hospital, offering a warm and friendly environment for women and their partners.

There have been major improvements to car parking at the hospital, with the introduction of barrier car parking with an extra 50 spaces created in winter 2007 in the main car park.

The Trust owns the Acre Mill site opposite Huddersfield Royal Infirmary and this new development for out patients' services was opened in 2015, freeing up valuable space on the main hospital site for expansion.

A major part of this is the opening of an £8 million pharmacy manufacturing unit on the site in spring 2008, which will produce pharmaceutical products for people across the country.

A new state of the art Endoscopy unit was built in 2011 and the Trust embarked on a scheme to replace the ageing calorifiers with Plate Heat Exchangers which was completed in 2015.

The Trust is committed to carrying out a major ward refurbishment each year which will produce single rooms with en-suites, modernise the infrastructure and eliminate the nightingale wards.

Although there has been significant investment, the core building is considered to be beyond its useful life and is time expired.

Financial pressures have placed significant restraints on capital investment in recent years and as a result, the backlog of maintenance for time expired buildings requirement has grown.

8.3.1.4.1 Backlog of maintenance for time expired buildings

Backlog maintenance, with regards to the HRI site, refers to the costs associated with time expired buildings. The cost described in this section is the minimum investment required to bring the estate to a category B level.

In 2013, the Trust commissioned a 6 facet survey from NIFES Consulting group that identified the extent of capital works required to bring HRI to condition B status in accordance with the Department of Health Estate code.

The survey concluded that the Estate is overall in poor condition with significant backlog of maintenance for time expired buildings. The survey identified statutory items across the site that required immediate remedial action in large parts of the estate as well as key factor impacting on operational performance.

A significant investment is required to resolve the functional suitability of the estate. This has been driven through changes in service provision and size of teams that has meant the parts of the current estate are too small or were constructed and designed for another function which does not provide a suitable layout and space for services.

The 2013 survey estimated costs for upgrade of time expired buildings to be c£39m as per the table below:

Facet	Cost £
Physical Condition	14,036,326
Physical Condition - Infrastructure	4,174,440
Statutory Compliance	49,200
Statutory Compliance - Infrastructure	604,350
Quality	780,587
Quality – Infrastructure	5,000
Function and Suitability	18,563,530
Space Utilisation	821,812
Environmental	321,834
Total	**39,357,079**

Table 61: Backlog maintenance and upgrade costs survey, 2013.

Since the 6 facet surveys were carried out in 2013 there has been a further deterioration of the estates building and engineering service infrastructure and space/functional suitability. This has been compounded by significant restrains on capital investment for backlog maintenance due to financial pressures.

The Trust now carries a high risk in terms of the condition and reliability of its building and engineering services infrastructure at HRI. The age and condition of the estate is such that without significant capital injection in backlog maintenance there is a high risk of failure of critical services such as power supply, heating, hot and cold water services and medical gas services. The building and engineer service were designed in the 1960s and based on a demand and capacity model at that time. Since this time, further increase in load requirements have seen greater demand on system capacity and ability to provide the high levels of resilience required an in acute hospital site. Any additional load resulting from extinctions to the building would result in further pressure on the system infrastructure.

Some of the major risks that could impact on the viability and operation of the site include:

- Corroded service pipework that could potentially fail - expediting the required repairs could cause significant disruption to patient services and care due to the location of asbestos in the building.
- Roof repairs are required throughout the building – there has been an increase in water leakage into the building and patient areas including wards and treatment areas.
- Power supplies require significant work – although there have been improvements; there still remains further work required to secure a robust supply.
- Fire safety – although improved, there still remains a significant investment requirement for compartmentation, fire detection and alarm systems.
- The vast majority of windows require replacements – there are multiple instances of windows leaking and allowing a significant draft to penetrate into the building having a sever effect on the patient environment, comfort and experience.
- Asbestos removal –The Trust has strong management processes in place around the asbestos within the hospital infrastructure. The requirement for asbestos removal, should any infrastructure repairs be required, could have a major impact on the provision of patient services and care.

The 6 facet surveys where reassessed as part of the Cost Management Plan in support of the various estates reconfiguration options being assessed as part of this plan. The shift statement, produced by Lendlease Consulting Limited in November 2015, identified that £92m would now be required with the vast majority required immediately.

The backlog maintenance requirement is a key consideration in determining the capital investment required under each of the proposed estate options.

8.3.1.5 The Trust's capital plan

A large part of the Trust's capital plan between FY17 and FY22 is dependent on the site configuration chosen. This section outlines the existing capital plan that is not influenced by the site configuration chosen and the implications of each of the site configurations.

8.3.1.5.1 Capital costs not dependent on site configuration

The table below is the capital expenditure plans submitted to DH in January 2015. The planned expenditure for backlog maintenance has been removed from this submission to avoid a double count with the estate capital requirement under each option.

Category (£000)	FY17	FY18	FY19	FY20
Estates	4,268			
Theatre Refurbishment Programme	1,321		-	-
Information Technology	2,170	6,400	3,300	5,500
EPR	5,501	-	-	-
Equipment	1,000	1,000	1,000	1,000
PFI – Lifecycle	1,455	1,540	1,570	1,668
Total	**15,715**	**8,940**	**5,870**	**8,168**

Table 62: Capital expenditure plans submitted to DH in January 2015

Ongoing replacement and maintenance capital expenditure in FY21 and FY22 have been assumed to be equal to the annual depreciation charge.

Alongside this, there is a capital investment requirement into the PMU of £300k per annum from FY18 to FY21. This is required to support recurrent strategic saving of £1.0m to £1.5m through an increase in contribution from the service. This is not included within the "Do Nothing" option within the finance case. This is shown in the table below:

Category (£000)	FY17	FY18	FY19	FY20	FY21	FY22
PMU		300	300	300	300	

Table 63: Capital investment requirement for PMU

8.3.1.5.1.1 Capital expenditure requirement for IMT

The Trust has identified IMT improvements that will drive significant patient benefits and improve staff productivity. The most significant of these is the implementation of EPR and PACS replacement programmes which is expected to go live in FY17. This expenditure was included within the original capital forecast presented to Department of Health in January 2015.

The phasing of capital expenditure on IMT is shown below:

Clinical and IMT systems (£000)	FY17	FY18	FY19	FY20
Maternity PAS			500	
Theatres		700		
PACS replacement		2,500		
EPR (Hardware and Software)	5,501			
EPR (Procurement and consultancy)				
EPR Training	70			
Pathology		1,200		
Other	600	500	700	2000
IT Infrastructure	1,500	1,500	2,100	3,500
Total	**7,671**	**6,400**	**3,300**	**5,500**

Table 64: Phasing of capital expenditure on IMT

The capital investment programme beyond FY19 is yet to be determined.

8.3.1.5.1.2 Expected benefits from EPR implementation

The EPR implementation is expected to deliver significant benefits for the Trust. Some of the key benefits include:

- Improves patient care and safety
- Improves working practices
- Improves Management reporting
- Improves management of litigation risks
- Improves efficiency
- Removes wastage

The benefits of the implementation are wide reaching and are expected to deliver financial benefits of £4.1m after implementation and go-live.

8.3.1.6 Estates capital expenditure

There were seven estate options that were considered as part of the estates configuration within the Clinical Model.

Option	Description
Option 1	Backlog maintenance only
Option 2a	HRI unplanned care site; CRH planned care site; New build on Acre Mills
Option 2b	HRI unplanned care site; CRH planned care site; New build on HRI
Option 2c	HRI unplanned care site; CRH planned care site; Extend HRI
Option 3a	CRH unplanned care site; HRI planned care site on Acre Mills; New Build behind Maternity
Option 3b	CRH unplanned care site; HRI planned care site on Acre Mills; New Build on Allotments
Option 3c	CRH unplanned care site; HRI planned care site on Acre Mills; New Build in lieu of F Block

Table 65: Seven estate options

An assessment from Lendlease identified that the potential costs of option 2a and 2b were significantly higher than option 2c. It was also agreed by the Trust that pursuing either option 3b or 3c would pose significant risk particularly related to the availability of land that was not currently under the ownership of CHFT.

It was for this reason that options 1, 2c and 3a were progressed further for full appraisal.

8.3.1.6.1 Capital expenditure for backlog maintenance only

This option was progressed as this would represent the "do minimum" option. The significance of the risks identified through backlog maintenance has meant that the Trust would need to assume this expenditure would need to be incurred within the 5 years (FY18 to FY22).

This represents a total capital expenditure of £92m. The elements of this cost are shown in the table below:

Description	Cost (£)
Physical condition	16,355,822.75
Functional suitability	29,340,111.20
Quality	1,134,148.55
Space utilisation	1,697,000.00
Statutory compliance	53,200.00
Environmental management	1,636,683.00
Infrastructure - Physical condition	4,319,000.00
Infrastructure – Quality	5,000.00
Infrastructure – Statutory compliance	1,255,000.00
Subtotal	**55,795,965.50**
Preliminaries (15%)	8,369,394.82
Fees (12%)	7,699,843.24
Contingency (10%)	6,416,536.03
VAT (Excluding fees)	14,116,379.27
TOTAL	**£92,398,118.86**

Table 66: Capital expenditure for backlog maintenance

It is assumed that the capital expenditure would be phased evenly over the 5 years as per the below.

	FY17	FY18	FY19	FY20	FY21	FY22	Total
Capital expenditure (£m)	18.5	18.5	18.5	18.5	18.5	-	**92.4**

Table 67: Capital expenditure phasing for backlog maintenance

Under this option, the total capital expenditure would be £156.0m:

Capital Expenditure (£m)	FY17	FY18	FY19	FY20	FY21	FY22	Total
Existing Capital Plan (Submitted to DH January 2015)							
Estates	4.3	-	-	-	-	-	**4.3**
Theatre Refurbishment Programme	1.3	-	-	-	-	-	**1.3**
Information Technology	2.2	6.4	3.3	5.5	-	-	**17.4**
EPR	5.5	-	-	-	-	-	**5.5**
Equipment	1.0	1.0	1.0	1.0	-	-	**4**
PFI – Lifecycle	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**
Other	-	-	-	-	10.2	10.2	**20.4**
Total existing Capital Plan	15.7	8.9	5.9	8.2	11.9	11.9	**62.4**
PMU		0.3	0.3	0.3	0.3		**1.2**
Backlog at HRI	18.5	18.5	18.5	18.5	18.5	-	**92.4**
TOTAL	**34.2**	**27.7**	**24.6**	**26.9**	**30.6**	**11.9**	**156.0**

Table 68: Forecast capital expenditure under 'do minimum' option

8.3.1.6.2 Capital expenditure for HRI as the unplanned care site with an extension and CRH as the planned care site

The Clinical Consensus Model is site agnostic and therefore CHFT had to consider whether unplanned care would be provided on either the CRH or HRI site. This option provided the best economic option in terms of those considered with HRI as the unplanned care site.

This option represents a total capital expenditure requirement of £301m. The elements of this cost are shown in the table below:

Element	Cost (£)
HRI	66,795,028
CRH	7,815,250
Site infrastructure	3,366,550
Traffic management	100,193
External works	635,850
Service diversions	180,000
Access and logistics	200,385
Car parking	5,000,000
Links	150,000
Sustainability	746,103
Section 106/278	746,103
	85,735,461
Preliminaries	12,002,965
Fees	11,728,611.05
Non works costs	1,466,076
Equipment costs	4,886,921.27
Planning contingency	17,373,005
Optimism bias (13%)	17,315,095
	150,508,134
Inflation	27,332,277
VAT (Excluding Fees)	33,222,360
VAT recovery	-2,383,318
TOTAL	**208,679,454**
Backlog maintenance	**92,398,119**
Total (including backlog)	**301,077,573**

Table 69: Capital expenditure for HRI as unplanned care site

Of note, backlog maintenance for time expired buildings would need to be invested over a shorter period of time in order to support the site extension at HRI.

Although the vast majority of capital investment is required at HRI, it should be noted that investment would also be required at CRH to make the site functionally suitable and appropriately extended for the intended future use as a planned care site. This would include an Urgent Care Centre (UCC).

The phasing of the proposed capital expenditure is show below:

	FY17	FY18	FY19	FY20	FY21	FY22	Total
Backlog and upgrade maintenance	46.2	23.1	23.1	-	-	-	**92.4**
New build	-	69.6	69.6	69.6	-	-	**208.7**
Total Capital	**46.2**	**92.7**	**92.7**	**69.6**	**-**	**-**	**301.1**

Table 70: Phasing of proposed capital expenditure on estates with HRI as the unplanned care site

The phasing of backlog maintenance has been moved forward as this option would greatly increase demand on existing service which would not be able to cope with any increase in capacity requirements due to its age and condition.

Under this option, the total capital expenditure would be £364.7m:

Capital Expenditure (£m)	FY17	FY18	FY19	FY20	FY21	FY22	Total
Existing Capital Plan (Submitted to DH January 2015)							
Estates	4.3	-	-	-	-	-	**4.3**
Theatre Refurbishment Programme	1.3	-	-	-	-	-	**1.3**
Information Technology	2.2	6.4	3.3	5.5	-	-	**17.4**
EPR	5.5	-	-	-	-	-	**5.5**
Equipment	1.0	1.0	1.0	1.0	-	-	**4**
PFI – Lifecycle	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**
Other	-	-	-	-	10.2	10.2	**20.4**
Total existing Capital Plan	15.7	8.9	5.9	8.2	11.9	11.9	**62.4**
PMU		0.3	0.3	0.3	0.3		**1.2**
Backlog at HRI	46.2	23.1	23.1	-	-	-	**92.4**
Site reconfiguration capital		69.6	69.6	69.6	-	-	**208.7**
TOTAL	**61.9**	**101.9**	**98.9**	**78.1**	**12.2**	**11.9**	**364.7**

Table 71: Total capital expenditure with HRI as the unplanned care site

8.3.1.6.3 Capital expenditure for CRH as the unplanned care site and Acre Mills as the planned care site

The Clinical Consensus Model is site agnostic and therefore CHFT had to consider whether unplanned care would be provided on either the CRH or HRI site. Without allowing for any cost impact from variation to the existing PFI contract, the best economic option in terms of those considered is a reconfiguration with CRH as the unplanned care site and Acre Mills as the planned care site.

This option represents a total capital expenditure requirement of £291m. The elements of this cost are shown in the table below:

Element	Cost (£)
HRI (Acre Mills)	55,480,150
CRH	46,503,600
Site infrastructure	5,370,240
Traffic management	152,976
External works	1,070,080
Service diversions	140,000
Access and logistics	139,511
Car parking	5,000,000
Links	90,000
Sustainability	1,019,838
Section 106/278	1,019,838
	115,986,231
Preliminaries	16,238,072
Fees	15,866,916.46
Non works costs	1,983,365
Equipment costs	6,611,215.19
Planning contingency	23,502,870
Optimism bias (13%)	23,424,527
	203,613,197
Inflation	36,976,157
VAT (Excluding Fees)	44,944,487
VAT recovery	-9,855,521.50
Total	**275,678,320**
Backlog maintenance	**15,500,000**
Total (including backlog)	**291,178,320**

Table 72: Capital expenditure for CRH as unplanned care site

The vast majority of the investment is required at Acre Mills to support the development of a new build (and UCC) with less investment required at CRH for expansion and upgrade.

The phasing of the proposed capital expenditure is show below:

	FY17	FY18	FY19	FY20	FY21	FY22	Total
- Backlog maintenance	15.5	-	-	-	-	-	**15.5**
- New build / Upgrade		91.9	91.9	91.9	-	-	**275.7**
Total Capital	**15.5**	**91.9**	**91.9**	**91.9**	**-**	**-**	**291.2**

Table 73: Phasing of proposed capital expenditure on estates with CRH as the unplanned care site

The backlog/upgrade requirement has been reduced under this option due to the expectation that the HRI site will no longer be utilised once works have been completed. £15.5m of capital investment is required to ensure the Trust provides a safe and suitable environment for patients and staff in the interim. This does not bring the HRI site to Condition B status.

There is an expectation that the land on which the HRI site has been developed could be sold for a net £7m in FY21 on completion of works. This is significantly lower than the current net book value of the building and lands. Alternative options for the disposal of the site would need to be explored should this be the preferred option.

Under this option, the total capital expenditure would be £354.8m:

Capital Expenditure (£m)	FY17	FY18	FY19	FY20	FY21	FY22	Total
Existing Capital Plan (Submitted to DH January 2015)							
Estates	4.3	-	-	-	-	-	**4.3**
Theatre Refurbishment Programme	1.3	-	-	-	-	-	**1.3**
Information Technology	2.2	6.4	3.3	5.5	-	-	**17.4**
EPR	5.5	-	-	-	-	-	**5.5**
Equipment	1.0	1.0	1.0	1.0	-	-	**4**
PFI – Lifecycle	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**
Other	-	-	-	-	10.2	10.2	**20.4**
Total existing Capital Plan	15.7	8.9	5.9	8.2	11.9	11.9	**62.4**
PMU		0.3	0.3	0.3	0.3		**1.2**
Backlog at HRI	15.5	-	-	-	-	-	**15.5**
Site reconfiguration capital	-	91.9	91.9	91.9	-	-	**275.7**
TOTAL	**31.2**	**101.1**	**98.1**	**100.4**	**12.2**	**11.9**	**354.8**

Table 74: Total capital expenditure with CRH as the unplanned care site

8.3.1.7 Summary

The table below shows the capital expenditure required under each of the estate options.

	FY17	FY18	FY19	FY20	FY21	FY22	Total
Backlog maintenance only	34.2	27.7	24.6	26.9	30.6	11.9	**156.0**
HRI unplanned care site; CRH planned care site; Extend HRI	61.9	101.9	98.9	78.1	12.2	11.9	**364.7**
CRH unplanned care site; HRI planned care site on Acre Mills; New Build behind Maternity	31.2	101.1	98.1	100.4	12.2	11.9	**354.8**

Table 75: Summary of estate option capital

8.4 Commercial case for change

CHFT's financial performance is weakening. Service and site reconfiguration presents a compelling opportunity to improve the financial and clinical sustainability of health provision for the people of Greater Huddersfield and Calderdale.

- **The Trust has poor and deteriorating financial performance.**
- **The Trust is currently clinically unsustainable.** There are a number of services that are either non-compliant or not fully compliant with current standards.
- **Reconfiguration of services represents the best option for delivering sustainable high quality health services.** Commercial benefits of this reconfiguration include:
  - **£16.0m in strategic savings opportunities** (£18.0m in nominal terms) that can be driven through implementation of an agreed clinical model
  - **A further £6.7m of strategic savings have been identified** (£7.4m in nominal terms) that are not dependent on a site reconfiguration
  - **Implementation of a clinical model that is strongly aligned with commissioners' intentions and the needs of the local population** - subject to consultation
  - **A more efficient configuration of services** to improve operational efficiencies and create synergies within the hospitals
  - **A significant investment in the local health economy –** the site reconfiguration will enable wider scale strategic changes in the way that healthcare is provided to the local population.
- **Commissioners are supportive of the proposed reconfiguration, and will make a decision on whether to commence public consultation in January 2016.**
- **There is a currently a discrepancy in forecast income of the Trust of £22.3m by FY22 between the Trust and commissioners.**
  - **This is primarily driven by differences in QIPP assumptions.** Specifically in relation to QIPP, the Trust is expecting a reduction in income of £12.4m relating to QIPP whereas commissioners are expecting £27.2m.
- **QIPP expectations and plans will be managed throughout the period to reduce avoidable non-elective admissions** through improved management of care in alternative settings.
  - The Trust and the commissioners will work together to improve patient outcomes and financially benefit the health economy as a whole.
  - The Trust and the commissioners will work together to improve patient outcomes and financially benefit the health economy as a whole. This reflects the Trust's support for more care out of hospital through QIPP.
  - A reduced QIPP value compared to commissioners' plans has been incorporated as a planning assumption to mitigate risk of under delivery and a design of a future hospital model that may have insufficient capacity.

8.4.1 Introduction

There is a strong commercial case for reconfiguration. The performance of the trust is not financially, clinically or operationally sustainable in its current form and the proposed reconfiguration provides the clearest option to move towards sustainability.

The Clinical Model is fully aligned to the local Commissioners' intentions for future service provision across Calderdale and Greater Huddersfield as set out in the Clinical Consensus Model that was co-developed by the commissioners and other key local health economy stakeholders, including CHFT.

This section sets out the current clinical and financial performance of the Trust, the options that were considered, the process for engaging with commissioners on the proposed changes and the ultimate benefits to the Trust and the health economy.

8.4.2 CHFT current performance

This section summarises the key clinical and financial factors that characterise the Trust. These are further detailed in the financial and clinical cases for change and are included here to provide context.

8.4.2.1 Clinical

The following characteristics highlight CHFT's current clinical performance:

- CHFT generally provides high quality patient care despite the current challenges it faces
- Clinical sustainability issues exist at CHFT in a number of areas – for example, the Trust is currently not compliant with Royal College of Paediatrics and Child Health and Royal College recommendation that a consultant Paediatrician is present and readily available in the hospital during times of peak activity, seven days a week
- There are ongoing issues with recruitment and retention, particularly in medical specialties where dual site working results in a 1:5 on-call rota for Consultants which results on a heavy reliance on locum staff to maintain the service
- The Trust has a hospital standardised mortality ratio which is above the national average
- Dual-site working presents challenges particularly where colocation of dependent specialties is not possible.

8.4.2.2 Financial

The following characteristics highlight CHFT's current financial performance:

- Dual-site working creates financial pressures on the organisation as the Trust is unable to benefit from economies of scale and benefits arising from adjacencies of services. This has been estimated to create a premium cost of £4.6m per annum
- The PFI at CRH creates an increasing financial pressure outside the control of the organisation with an estimated premium cost of £4.8m per annum
- The Trust is significantly underperforming against Monitor financial regulatory requirements with a Continuity of Service Risk Rating score of 2 and a red governance rating
- The Trust is currently forecasting a £34.1m deficit in FY17.

8.4.3 Addressing the challenges faced by the Trust

In order to address the clinical and financial challenges, shown above, the Trust and Commissioners agreed that reconfiguration of services and a review of the estate options that underpinned the delivery of services would be the most impactful route to sustainability.

8.4.3.1 Developing the Clinical Model

As part of a whole system approach, the Clinical Model underpinning the future model of care for hospital services in Calderdale and Greater Huddersfield was developed as a result of collaboration between commissioners and other key local health economy stakeholders. It is built on the work and investment undertaken by commissioners as part of their care closer to home programmes to strengthen and enhance community service provision, considered to be phases 1 and 2 of commissioner strategies to ensure that health and social care services are fit for the future. Phase 3 is focussed on hospital changes to support this aim.

The Clinical Consensus Model outlining the future provision of hospital care is the result of collaboration between clinicians from primary and secondary care, specifically from both Calderdale and Greater Huddersfield CCGs and the Trust.

The Clinical Consensus Model is further described in the Clinical case. The Clinical Model led the commissioners and CHFT to consider various estate configurations that could underpin the delivery of services.

It was agreed that the base case (the counterfactual) against which the impact of the clinical and estate options would be assessed would be one that involved minimum change in hospital configuration but would incorporate known changes.

8.4.3.2 Assessing the estate options

The below long list of estate options were jointly considered by the Commissioners and the Trust with the list being narrowed down by discounting those that would not be financially, operationally or clinically viable

Option	Configuration	Description of Assessment	Shortlist
1	**The Base Case** Minimum change in hospital configuration across two sites but incorporates known changes that will occur in next 5 years (e.g. demographic, tariff impacts, initiatives unrelated to hospital reconfiguration).	► Not in line with the Clinical Model ► The base case must be included in the strategy to understand the impact of the reconfiguration options.	**YES**
2	**All current Hospital Services provided at CRH** All existing hospital services provided at CRH i.e. a single hospital site proposal**.** Dispose of HRI and Acre Mill sites.	► No guarantee that capacity will be sufficient to service the local community ► Requires extensive reconfiguration and capital investment.	**NO - Discount**
2a	**All Hospital Services provided at CRH enabled by a retracted range of services provided by CHFT** The trust reduces market share to ensure all services can be delivered from CRH site only i.e. single hospital site proposal**.** Dispose of HRI and Acre Mill site	► No guarantee that capacity will be sufficient to service the local community ► Requires extensive reconfiguration and capital investment.	**NO - Discount**
3a	**All Hospital Services at HRI – Use Break Clause for PFI** All hospital services provided at HRI i.e. a single hospital site proposal. Exit CRH site through use of PFI break clause.	► No guarantee that capacity will be sufficient to service the local community ► Requires extensive reconfiguration and capital investment. ► PFI break clause expected to be £200m and not available for 30 years.	**NO - Discount**
3b	**All Hospital Services at HRI –Trust sublets / finds alternate use of CRH** All hospital services provided at HRI i.e. a single hospital site proposal. Alternate use of CRH secured.	► No guarantee that capacity will be sufficient to service the local community ► Requires extensive reconfiguration and capital investment. ► Likelihood of securing alternate use that would cover PFI cost is low	**NO - Discount**
4(a)	**Emergency and Acute Care Centre and high risk planned care delivered at CRH.** CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on main site (dispose of Acre Mill).	► In line with Clinical Model ► Safer / higher quality services, ► 24hr consultant led care ► Undisturbed planned care ► More resilient workforce model ► Capital receipt from sale of Acre Mill	**YES**
4(b)	**Emergency and Acute Care Centre and high risk planned care delivered at CRH.**	► In line with Clinical Model ► Safer / higher quality services ► 24hr consultant led care	**YES**

Option	Configuration	Description of Assessment	Shortlist
	CRH provides all acute and emergency care and clinically high risk planned care. Elective services are provided at HRI site on Acre Mill site (dispose of main site).	► Undisturbed planned care ► More resilient workforce model ► Capital receipt from sale of HRI	
5(a)	**Emergency and Acute Care Centre and high risk planned care delivered at HRI.** HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site.	► In line with Clinical Model ► Safer / higher quality services ► 24hr consultant led care ► Undisturbed planned care ► More resilient workforce model	**YES**
5(b)	**Emergency and Acute Care Centre and high risk planned care delivered at HRI.** HRI provides all acute and emergency care and clinically high risk planned care. Elective services are provided at CRH site and alternate use of some of CRH estate is explored to optimise PFI utilisation.	► In line with Clinical Model ► Safer / higher quality services ► 24hr consultant led care ► Undisturbed planned care ► More resilient workforce model	**YES**
6	**New build** Exit both CRH and HRI sites and build new hospital delivering all services on alternate site.	► In line with Clinical Model ► Safer / higher quality services ► 24hr consultant led care ► Undisturbed planned care ► More resilient workforce model ► Requires extensive capital investment. ► Funding highly unlikely to be provided ► PFI break clause expected to be £200m and not available for 30 years ► Likelihood of securing alternate use that would cover PFI cost is low.	**NO - Discount**
7	**Growth of activity and income on both sites to improve financial & clinical viability negating need for reconfiguration** Maximise income from both sites via increased market share to enable improved income and viability.	► Not in line with Clinical model ► Unlikely to be able to secure sufficient market share / growth to enable improvement in financial and clinical viability.	**NO - Discount**

Table 76: Long list of estate options

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8.4.4 Commissioner engagement

As previously described, the commissioners and CHFT have worked together to both agree the Clinical Model and the estate options to be considered to deliver the model. Through the assessment of each of the agreed estate options described above, there has been a process of engagement with the local CCGs. This section outlines the process for that engagement and the outcomes and areas for ongoing development.

The two local CCGs, Calderdale and Greater Huddersfield, have been involved throughout the development of the 5 Year Strategic Plan and have had the opportunity to present their views and input to the process. The development of the Plan has been the culmination of extensive joint working and collaboration between the Trust and its commissioners over a significant time period.

As mentioned previously, the Commissioners and the Trust are aligned on the Clinical Consensus Model and have developed that model through extensive primary and secondary care clinician engagement.

A joint planning group was set up with involvement from the CCGs, the Trust, Monitor and NHS England. The table below was a jointly agreed milestone plan used for engagement with all those in attendance at the joint planning group.

Milestone	What will be shared	Date of Completion
1. **Joint** agreement on meeting schedule, and key milestones for each meeting. Financial forecast assumptions requested.	► Milestones for the meetings over the 12 weeks through to end 2015 ► High level programme plan. *Note: Request for baseline financial assumptions to be shared post meeting.*	Meeting 1: 7th October
2. **Joint** discussion on strategic commissioning intentions, 5 year plans and status, and joint review of commissioner requested services	► Commissioner strategic commissioning intentions. ► Commissioner requested services. ► Initial commissioner view (if available) on impact of strategic initiatives such as 'Care Closer to Home' and 'Right Care, Right Time, Right Place' – specifically on activity, capacity and income.	Meeting 2: 21st October
3. **Trust** to share assessment criteria	► Criteria for assessing the estate configuration options developed by the CHFT Board, in light of the agreed Clinical Model.	
4. **Trust** to share list of estate configuration options to be assessed	► Long list of estate configuration options for appraisal ► Estate options that can be discounted in advance of quantification based on the criteria ► Estate options to be taken forward for quantitative modelling.	
5. **Joint** review of equality impact in light of estate options and travel analysis undertaken to date	► Travel time analysis previously undertaken. ► Narrative (as developed in the OBC) on equality impact of the options across the two main sites.	Meeting 3: 9th November
6. **Joint** comparison of financial assumptions and forward income baseline forecasts	► Comparison between Trust and CCG assumptions on: ► Commissioning intentions for FY17 ► QIPP assumptions (% or value of income)	

	► Growth forecasts over a 5 year period ► Tariff deflator assumptions ► Winter funding (and other non-recurrent funding) forecast spend over a 5 year period ► Other income/activity adjustments over a 5 year period not covered in the above ► Bridge from current year forecast outturn to position over 5 years incorporating the above. Note: This will be developed by the Trust based on the information received from the Commissioners.	
7. **Commissioners** to share detailed assumptions underpinning strategic plans	► Detailed QIPP plans – identifying activity type and impact for each (e.g. X% reduction in LTC patients in year Y), including capacity (beds) and income. ► Detailed plans underpinning any other significant changes to activity forecast or commissioning intentions within the 5 year period – specifically expected impact on CHFT in terms of required capacity (beds) and income.	
8. **Trust** to share activity and patient flow modelling a. Impact of technology b. Implications for estate and workforce	For the base case and each shortlisted reconfiguration option: ► Expected activity by site ► Expected beds, theatres and outpatient clinic requirements by site ► Workforce requirements by site. This will be split into the impact of the reconfiguration itself, and the impact of other initiatives.	Meeting 4: 30th November
9. **Trust** to share quality impact assessment	► Quality impact assessment for each of the shortlisted reconfiguration options.	
10. **Commissioners** to share finalised equality impact assessment	► Equality impact assessment for each of the shortlisted reconfiguration options.	
11. Trust to share financial forecast (excluding capital expenditure impact)	► Trust to share outputs from detailed activity and income modelling. This will include: ► Future Trust income projections ► Impact on other providers ► Assumptions on income for activity that has changed setting (e.g. Activity that has moved from Acute to Community) ► Impact by CCG/Commissioner. ► Commissioners to share updated assumptions (QIPP, Growth etc.) to determine level of convergence.	
12. Trust to share financial forecast (including capital expenditure impact)	► Trust financial forecasts over a 5 year period. This will include: ► Surplus/Deficit position and key drivers for change in position. ► Capital requirements ► Cash and working capital position ► Funding requirement ► Anticipated sources of funding.	Meeting 5: 10th December

13. **Joint** review of wider benefits	► Trust listing of benefits from the reconfiguration. ► Commissioner listing of benefits from the reconfiguration.	
14. **Joint** confirmation of preferred option	► Any refinements to the modelling and financial forecasts. ► Description of the final configuration model.	Meeting 6: 22nd December

8.4.4.1 Outcome of commissioner engagement

Following the engagement with commissioners through the process outlined above, there are areas where the Trust and the commissioners are in agreement and some, largely financial, areas where there are differences. These differences should not prevent either the commissioners or the Trust proceeding towards an agreement on the preferred option.

8.4.4.1.1 Key areas of agreement

The CCG remain committed to the Clinical Consensus Model and recognise that significant reconfiguration of services and sites are required to deliver the planned changes. In particular, the CCGs are supportive of:

- The implementation of the Clinical Model agreed within the Clinical Consensus document
- Development of opportunities to reduce non-elective medical activity, building on the work undertaken through the vanguard and Care Closer to Home initiatives
- A reduction of the number of beds in an acute setting with a greater focus on delivery of care in more appropriate settings and in the community

8.4.4.1.2 Activity and financial forecasts

Comparison of baseline activity and financial assumptions has shown that although there is alignment on the expectation to reduce hospital based activity through commissioner led QIPP programmes. A comparison of the financial forecasts between the Trust and the CCG still shows some differences for the reasons explained below:

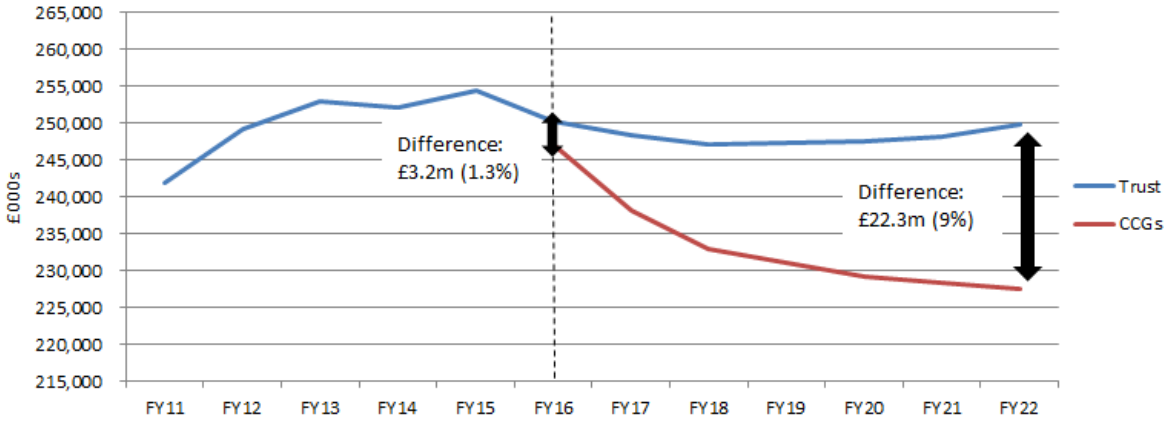


Table 77: Comparison between Trust and Commissioners income forecasts

- **Forecast outturn for FY16**

  The Trust has an expectation of higher income for FY16 than each of the commissioners. This is based on the assumption that the Trust will have additional capacity towards the end of the year with which to deliver additional elective activity. The Trust and the CCG will manage the in-year performance through the normal contractual monitoring route.

- **Demographic growth**

  The Trust has assumed a c1-2% growth on activity over the period. This is aligned with commissioners, although Huddersfield CCG is forecasting a higher rate of non-elective growth although this will be managed through QIPP. The Trust plans are based on the expectation that QIPP plans will deliver and any variation in demographic growth will be managed by the commissioners through development of further QIPP initiatives.

- **QIPP / Demand management**

  The Trust recognises the impact that Vanguard and other demand management schemes will have on the assumed levels of activity and income. This is crucial to delivering a clinical model that relies less on acute hospital based care. The Trust has assumed a 6% reduction in non-elective medical activity per annum from FY18 onwards. This reduces income by c£2.5m per annum across both Greater Huddersfield and Calderdale CCGs. The commissioners are expecting a greater financial reduction (including FY17) with an expectation as shown below:

  - Calderdale CCG - £2.8m per annum (for FY17 to FY20 and £2m per annum thereafter)
  - Greater Huddersfield CCG - £2.0m per annum

- **Care Closer to Home**

  The Trust has not included the impact of Phase 2 Care Closer to Home or any impact of Care Closer to Home on Calderdale. These are areas that are yet to be agreed and the impact of these will be agreed through the contract negotiations into FY17.

- **Funding for GP provision at the Urgent Care Centre**

  The Trust has assumed that the GP provision at the urgent care centre on the planned care site will be funded by commissioners on a pass-through basis, at a cost of £510k per year (in real terms).

QIPP is the largest driver of the differences between the Trust and the CCG. The Trust is expecting a reduction in income of £12.4m relating to QIPP whereas commissioners are expecting £27.2m. The reason for the difference is that commissioners have included QIPP of £4.8m in their plans for FY17 whereas the Trust have not and the value of year on year QIPP delivery is c£2.3m higher in commissioner plans.

QIPP expectations and plans will be managed throughout the period with a common expectation to reduce avoidable non-elective admissions through improved management of care in alternative settings. The Trust and the commissioners will work together to maximise the impact of QIPP to improve patient outcomes and financially benefit the health economy as a whole.

8.4.5 Benefits for commissioners and the health economy

8.4.5.1 Best option available

The table below summarises the expected benefits for each of the options considered. A reconfiguration presents the best option as it provides alignment to an agreed Clinical Model which will improve quality of service delivery and also provide the greatest opportunity for financial sustainability. This is further detailed in the financial and clinical cases.

Estate option	Expected benefits
Base case - 1	► Initiative savings amounting to £6.7m ► No impact on travel time and no initial capital required ► Not aligned with the clinical consensus model (the baseline is the counterfactual)
CRH unplanned and HRI planned – 4(a) & 4(b)	► Expected reconfiguration savings of £16.0m with additional savings of £6.7m expected from implementation of the priority initiatives ► Supports the Trust in meeting clinical standards ► Minimal impact on patient's access to care ► A reduction in bed base has been modelling in line with QIPP. Bed numbers do not differ between option 4 and option 5.
HRI unplanned and CRH planned – 5(a) & (b)	► Expected reconfiguration savings of £13.1m with additional savings of £6.7m expected from implementation of the priority initiatives ► Supports the Trust in meeting clinical standards ► Minimal impact on patient's access to care ► A reduction in bed base has been modelling in line with QIPP. Bed numbers do not differ between option 4 and option 5.

Table 78: Options benefits appraisal

8.4.5.2 Secure funding into the local health economy

Major capital investment is required, in particular at the HRI site, to deliver safe clinical services in the medium to long term. The proposed reconfiguration represents an opportunity to resolve long standing estate backlog issues. The issues relating to backlog maintenance at the HRI site are further detailed within the Capital case.

8.4.5.3 Opportunity to improve quality

As described in the clinical case, the reconfiguration of services to align to the Clinical Consensus Model presents significant opportunities to stabilise current quality issues, including addressing the workforce issues. The clinical adjacencies also provide a greater opportunity for service improvement in terms of both quality and patient experience.

Examples of potential improvements in quality include:

- Improvement in recruitment and retention thereby reducing the reliance on locums
- Enables the Trust to meet quality guidelines such as College of Emergency Medicine guidance on medical workforce cover through consolidation of rotas
- Improvement in the patient experience through a more streamlined, efficient patient pathway as a result of acute services being co-located
- Realise the patient outcome benefits from co-location of acute services

8.5 Workforce

The Trust face considerable workforce challenges to the detriment of the resilience of clinical services, staff satisfaction and health and to the Trust finances. As such, workforce is one of the key factors driving the need for reconfiguration.

- **Workforce challenges include the following:**
  - Non-compliance with Royal College of Emergency Medicine's recommendations on Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant cover
  - Intense, fragile clinical rotas where unplanned services are provided at two sites
  - Recruitment, retention and vacancy challenges
  - Long term sickness absence challenges primarily relating to anxiety, stress and depression
  - Heavy reliance of locum staff – with £21.2m forecast expenditure for FY16
- **The challenges above arise specifically due to the current clinical service, and are addressed through the proposed reconfiguration of clinical services.**
- **Further to the reconfiguration, the Trust will employ broader strategic workforce initiatives to improve the quality and resilience of clinical services and improve opportunities for workforce, such as –** community collaboration with Pennine GP Alliance, Radiology pooling with West Yorkshire's Association of Acute Trusts, shared provision of pathology service across the patch, Primary care collaboration and integration, workforce skill mix changes and the use of technology (e.g. Telehealth and Telemedicine).
- **Staff whole time equivalents will reduce by 966 over the period (3.2% per annum)** of which 765 (79%) relates to delivering the annual efficiency requirement, 88 (9%) relates to non-configuration dependent strategic savings and 122 (12%) relates to delivering further savings associated with the proposed clinical reconfiguration – with the effects of growth and QIPP approximately offsetting one another with a net increase of five WTEs.
- **In developing the 5 year plan, the Trust's financial position is strongly constrained by CIP and QIPP requirements.** This in turn, has led to the need to develop a workforce plan to fit within this overall financial envelope.
- **It is assumed that business as usual turnover of staff, currently at 15.4%, will be sufficient to achieve the necessary reduction in WTEs without the need for redundancies.** No assumption has been made regarding re-investment in the community workforce model or the preferred provider of these services.

8.5.1 Workforce challenges

Workforce is one of the key factors driving the need for reconfiguration. The Five Year Strategic Plan and an accompanying Workforce Plan have been developed in response to a number of specific workforce challenges the Trust is facing in delivering sustainable, resilient and affordable clinical services for its local population. These challenges are highlighted as follows:

- **Meeting Royal College of Emergency Medicine's recommendations / standards**: both hospital sites operate an Emergency Department and a Critical Care Unit. The care provided under both of these services is either non-compliant with some of the standards for Children and Young People in Emergency Care settings or not fully compliant with D16 guidance on Critical Care workforce standards. For example, there are inadequate numbers of paediatric-registered nurses to cover both Emergency Departments. Furthermore, the two sites do not satisfy the College's recommendation of a minimum of 10 consultants per Emergency Department and for 14 hours a day consultant cover.
- **Intense, fragile clinical rotas**: the provision of services at two different sites and a significant number of staff vacancies has resulted in the Trust operating a number of high frequency clinical rotas. This places a considerable workload strain on staff and detracts from the resilience of the services as a whole. Examples include the 1 in 5 ED rota, the 1 in 11 Acute Medicine rota (neighbouring Trusts have a 1 in 15 rota) and the 1 in 5 Acute Medicine weekend rota.
- **Sickness absence**: 4.3% of the Trust total workforce is on sickness absence (of which 3.2% is long term sickness), though the rate is higher for a number of particular areas such as the Medicine Directorate which has a rate of 5.4% (of which 4.0% is long term sickness). Anxiety, stress and depression are by far the most commonly reported causes.
- **Recruitment, retention and vacancy challenges:** the Trust faces considerable recruitment and retention challenges, arising in vacancies in consultants and specialty/ middle grade doctors in a number of key clinical staff groups. These reflect both national shortages (Emergency, Paediatric and Radiologist consultants) and a variety of local factors which compound these. Examples include the cross site working, intense rotas, and reduced opportunities for sub-specialisation in Medical and Radiology rotas.

  The recruitment and retention of the medical workforce in the EDs is particularly challenging at both consultant and middle grade levels. The number of consultants across both sites is below establishment. There is a gap of 3 consultants with 9 being in post compared to an establishment of 12 (FY17 plan). This leaves the service heavily reliant on locum cover, however despite this there is still insufficient locum cover to cover the gap of 6 consultants.

  There have been particular difficulties recruiting to middle grade posts in ED leading to a workforce gap of 6 WTE posts against an establishment of 10. Of the 4 in post, 3 are unable to work nights due to occupational health issues leading to reliance on locum staff for service provision at night.

- **Heavy reliance of locum staff**: due to vacancies and a high sickness absence amongst the workforce, the Trust relies considerably on agency and locum staff to cover gaps in the workforce. This represents a considerable financial pressure for the Trust, with £21.2m agency and locum expenditure forecast for FY16. The Medicine (£12.5m) and Surgery & Anaesthetics (£4.8m) divisions account for 82% this expenditure, with junior doctors (£8.2m), nursing (£6.9m) and consultants (£4.3m) accounting for 87% from a staff group perspective.

CHFT does not currently have a comprehensive Workforce Strategy in place to address the above challenges, nor to define and deliver the future needs of the Trust's workforce in the face of the broader ongoing financial challenges facing the NHS. The need to development a Workforce Strategy is recognised as being a key priority for the Trust.

The Five Year Strategic Plan has been developed to address the challenges highlighted above both through a reconfiguration of clinical services across HRI and CRH and through further non reconfiguration related strategic initiatives.

The remainder of the workforce case is set out as follows:

- **Clinical reconfiguration**: details the specific workforce challenges facing particular clinical services, and the benefits arising from their reconfiguration across HRI and CRH.
- **Wider workforce initiatives**: highlights further broader workforce initiatives the Trust will employ to address current and future workforce and financial pressures.
- **The Workforce Plan**: details projected workforce numbers across the five year period along with commentary on the key factors driving these.

The following table highlights forecast FY17 locum and agency expenditure, long term sickness absence rates, staff turnover, vacancy rates and the proportion of staff eligible for retirement by Directorate:

	FY17 forecast	FY17 Q2 Year to Date Average			
Workforce statistics	**Agency / Locum cost**	**Sickness**	**Turnover**	**Vacancies per ESR**	**Eligibility for Retirement**
Surgery & Anaesthetics	£4.8m	4.3%	11.9%	2.1%	5.1%
Medical	£12.5m	5.4%	16.1%	6.3%	3.0%
Community	£0.0m	3.5%	20.0%	18.6%	2.7%
Families & Specialist Services	£2.3m	4.5%	14.4%	8.4%	3.4%
Estates & Facilities	£0.2m	4.7%	13.4%	13.6%	7.8%
Corporate	£0.7m	1.9%	18.9%	3.6%	3.8%
The Health Informatics Service	£0.8m	3.7%	17.3%	6.9%	2.0%
Trust	**£21.2m**	**4.3%**	**15.4%**	**7.0%**	**3.8%**

Table 79: Forecast locum and agency expenditure, long term sickness absence rates, staff turnover, vacancy rates and staff eligible for retirement

Gaps in current medical staffing in key areas against the Trust FY17 Plan are listed in section 10.6 of this plan.

8.5.2 Clinical reconfiguration benefits

As mentioned previously, workforce is one of the key factors driving the need for reconfiguration, particularly in relation to challenges faced by a number of the clinical services currently provided by the Trust.

This section sets out a short summary of the workforce benefits arising from the clinical reconfiguration, followed by the specific challenges and benefits detailed by clinical service area.

Workforce benefits are summarised as follows:

- **Royal College of Emergency Medicine's recommendations / standards**: the standards for Children and Young People in Emergency Care settings, Critical Care workforce standards and Emergency Department consultant and paediatric nursing cover recommendations will be satisfied through the consolidation of the unplanned service workforce on to one site.
- **Clinical rota resilience**: rota frequency will reduce immediately with the consolidation of unplanned services and workforce on to one site, thereby reducing the workload strain on staff and improving the resilience of services. Relevant services include ED, Acute Medicine, Critical Care, Paediatrics and Radiology.
- **Sub-specialisation of clinical services**: the critical mass achieved through consolidating of unplanned patients and workforce onto one site will allow greater opportunities for sub-specialisation of the workforce, improving the attractiveness of employment at the Trust and enhanced clinical services for patients. Relevant services include Paediatrics and Trauma sub-specialisation in ED, and Acute Medicine.
- **Skill mix / role improvements**: the Advanced Practitioner role will be further refined and deployed in the Trust to reduce reliance on the middle grade doctor workforce across many specialties including ED, acute medicine and paediatrics. There would be an opportunity for Radiography staff to be trained to work across a number of areas such as plain X-Ray and acute head scanning, which would provide broader development opportunities.
- **Improving junior doctor training, oversight and supervision**: junior doctor training and supervision is anticipated to improve for all clinical services being consolidated on to one site given the increased throughput of activity and the increased non-locum consultant presence on site.
- **Recruitment, retention and locum reliance:** it is anticipated that improvements in the key areas already described, such as rotas and extended roles, will improve the attractiveness of the Trust to future and existing staff and thereby increase recruitment opportunities and reduce staff turnover. In turn this will reduce the Trusts considerable reliance on locum and agency staff.
- **Long term sickness absence**: the factors above allow for more effective service planning, thereby reducing stress for staff and mitigating the Trust's long term sickness absence challenge.

This section details the specific workforce challenges facing the relevant clinical services, and the benefits arising from the clinical reconfiguration.

8.5.2.1 Medicine – ED services

8.5.2.1.1 Challenges

ED faces considerable recruitment challenges at both consultant and middle grade doctor levels. At present there is a shortfall of three ED consultants compared with an establishment of 12 (FY17

plan), and a shortfall of six middle grade doctors compared with an establishment of 10. The College of Emergency Medicine recommends a minimum of 10 consultants in Emergency Medicine per emergency department, whilst just nine are covering both the Calderdale and Huddersfield ED departments.

Recruitment difficulties reflect both national shortages of emergency doctors (nearly one fifth of consultant posts in ED departments are either vacant or filled by locums) and local factors, such as the lack of ED sub specialisation (e.g. paediatrics and trauma) and the intense frequency of rotas (1 in 5) which are both unattractive propositions for the workforce.

Both these local factors are driven primarily by the two site ED Clinical Model. This scenario has led to a considerable reliance on locum cover, particularly overnight during week days and during the weekends.

Based on current consultant capacity, the Trust is unable to meet the 14 hours a day consultant on site requirement as per the Royal College of Emergency Medicine, with consultant cover 8am - 5pm Monday - Friday with three vacancies.

8.5.2.1.1 Reconfiguration benefits

Under the proposed Clinical Model, the emergency department will be consolidated onto a single site. The clinical workforce would no longer be stretched across two departments and the College of Emergency Medicine recommendation of a minimum of 10 consultants in Emergency Medicine would be satisfied. Recruitment and retention are anticipated to improve with the considerable reduction in frequency of rotas.

Owing to vacancies, consultant cover in each ED is currently 8am-5pm Mondays- Friday, supported by middle grade doctors. Under the proposed service model, the Trust will be able to meet the 14 hours a day consultant on site requirement as per the Royal College of Emergency Medicine. This states that:

‘‘*Ten consultants can sustainably deliver one consultant on the shop floor 0800-2200, 7 days per week”*

Moving to a single site ED will ensure that the Trust will be in a better position to meet this recommendation with its ED consultant capacity.

The consolidation of patients and workforce onto one site is anticipated to improve training and supervision for junior staff (with increased on site consultant presence), optimise the use of middle-grade staff and increase the opportunity for subspecialisation noted as highly attractive to the workforce. Further to this, it is anticipated to and considerably reduce the Trust’s reliance on locum staff, enabling both improved service planning as well as delivering a more cost effective service.

It is anticipated that under the proposed Clinical Model, the Advanced Nurse Practitioner role will be further refined and deployed to reduce the burden on the stretched middle grade doctor workforce. In addition to promoting an attractive role for nurses, this is anticipated to reduce the reliance and workload burden on middle grade doctors and thereby improve recruitment and retention, as well as further reducing the Trust’s reliance on locum workforce.

The reconfiguration on to one site also provides an opportunity to reduce the amount of administrative support time required (currently 18 WTE in budget, including 8 receptionists per site), which could yield some efficiency savings in the number of admin staff required.

8.5.2.2 Medicine – Acute Medical Directorate

8.5.2.2.1 Challenges

Acute Medical services face similar challenges to ED services both in the recruitment and retention of workforce, with the retention of consultants particularly relevant in recent times.

Rota frequency is particularly intense, with a 1 in 11 week day rota (neighbouring Trusts' have a 1 in 15 week day rota) and a 1 in 5 weekend rota. Subspecialisation of the rota is limited to Stroke, Cardiology, Haematology and Oncology, whereas a greater critical mass of patients and staff would enable further specialisation into specialties such as Respiratory, Gastroenterology and Geriatrics. These factors contribute considerable to the recruitment and retention challenges, and are primarily features of managing unplanned services across two sites.

Other specific workforce challenges include:

- 50% or greater vacancies in consultant posts in Gastroenterology (2.5 WTEs in post compared with an establishment of 6), Geriatrics and in Dermatology, resulting in heavy reliance on locum and agency staff to deliver the service.
- Haematology operates an intense 1 in 4 rota during weekdays and over the weekend causing considerable strain on workforce and challenging the resilience and sustainability of service provision.
- Two of five Respiratory consultants are due to leave the Trust in December 2015 which will lead to considerable reliance on locum cover to provide services over the two sites.
- With regards to senior decision making such as patient referrals and discharges, the Trust is reliant on one Medical Registrar per site to cover the out of hours service between 8pm and 8am. On occasions where the registrar is called to ED or one of the wards, there are no further senior medical decisions makers on site to cover. This represents a challenging workload for Registrars and represents a risk to the future pipeline of consultants as registrars progress their careers.

8.5.2.2.2 Reconfiguration benefits

Under the proposed Clinical Model, all acute medical services will need to be located on the unplanned care site with the single ED for clinical adjacency purposes. Operating rotas over one site instead of two will reducing rota frequency for the medical workforce and thereby improve the Trust's ability to recruit and retain staff key to resilient service delivery, reducing reliance on locum staff.

Additionally, this consolidation on to one site is anticipated to improve training, supervision and oversight of junior doctors, increase the scope for subspecialisation of rotas supporting recruitment and retention, and to deploy staff more productively across a pooled activity base.

8.5.2.3 Surgery & anaesthetics – Operating Services, Theatres, Anaesthetics, Critical Care and Pain

8.5.2.3.1 Challenges

Critical care units are operated both at HRI and at CRH. Under this configuration of services, the Trust is unable to fully comply with D16 guidance on Critical Care workforce standards.

The service faces considerable recruitment and retention challenges especially with regards to ICU nursing. This has been attributed to the high frequency of overnight work required by ICU nurses at CHFT, and also to the situation whereby the ICU nurses are often redirected away from their ICU role to cover gaps in nursing workforce elsewhere in the Trust at short notice. These factors are often unattractive to nurses.

8.5.2.3.2 Reconfiguration benefits

Under the proposed Clinical Model, Level 2 and Level 3 ITU / Critical Care will be located on the unplanned care site (currently the Trust does not separate ITU and HDU, with beds being upgraded or downgraded as necessary). Patients requiring critical care will be transferred from the planned care site or identified in advance at the pre-assessment stage and Pain Services will be centralised at the planned care site.

This consolidation of activity would better enable the Trust to comply with D16 guidance on critical care workforce standards, improve training, supervision and oversight of junior doctors and improve resilience of the staff rota and thereby improve recruitment and retention.

8.5.2.4 Surgery & anaesthetics – Ophthalmology and ENT

Ophthalmology and ENT are currently provided at both HRI and CRH. Whilst these services do not face the same scale of challenges as other services highlighted above, the consolidation of these services on to one site is anticipated to improve training, supervision and oversight of junior doctors.

8.5.2.5 Children's services / Paediatrics

8.5.2.5.1 Challenges

The Paediatrics service is currently split between the both the HRI and CRH sites, with paediatric medicine provided at CRH and most of paediatric surgery at HRI. This has resulted in sub-optimal paediatric senior medical doctor oversight at HRI. Currently the EDs of CHFT are non-compliant with a number of the standards for Children and Young people in Emergency Care settings.

The service currently has a shortfall of 3.5 WTEs, with 7.5 Tier 2 doctors in place compared with an establishment of 11, the service deemed to require 10 WTEs to operate effectively. 11 speciality paediatric doctors are needed to cover existing rotas. The Trust has however developed the Advanced Paediatric Nurse Practitioner (APNP) role (Band 8A), and a similar role in NICU, the Advanced Neonatal Nurse Practitioner (Band 7), both of which can contribute to the medical or nursing workforce rotas. Whilst further work is ongoing in refining these roles, these mitigate pressure associated with the workforce shortage.

Paediatric recruiting challenges reflect both national and local shortages, and across the region there is a significant shortage in the number of paediatric specialist doctors in training starting in 2015.

8.5.2.5.2 Reconfiguration benefits

Under the proposed Clinical Model, specialist paediatric services will be co-located with the Emergency Care Centre. This will cover neonates, all paediatric surgery and paediatric medical care, with Neonates co-located with consultant led Maternity care.

Concentration of all emergency, acute medical and surgical paediatric services would enable optimal use of the medical workforce, crucial in the context of workforce shortfalls, and enable consultant oversight of across these services. It is anticipated that this will be a more attractive proposition to potential recruits, with a greater level of service stability, more sustainable rotas, and the potential for sub-specialisation.

Additionally, co-location of Paediatrics and Paediatrics EM will allow for Paediatric emergency medicine (PEM) trained staff to work alongside and support acute Paediatrics which also has significant workforce issues, especially in medical staffing.

8.5.2.6 Radiology

8.5.2.6.1 Challenges

At present there is a shortfall of four Radiology consultants against the establishment of 17, reflecting the national workforce shortage.

Sub specialty workforce challenges include the following:

- Breast Radiology has one consultant in post against the requirement of two to run a resilient service. Currently the Trust relies on external agreements and makes seasonal use of locums to strengthen the service.
- Interventional Radiology has a shortfall of one consultant against the establishment of four.
- Upper GI Radiology has no consultants in post against the establishment of one, the consultant having left recently and the Trust struggling to attract any interest in the post having advertised it.

8.5.2.6.2 Reconfiguration benefits

Under the proposed Clinical Model, it is anticipated that the majority of radiologists will work from the unplanned care site and report on the planned care site remotely. This would enable the merging of the current two site-based rotas into one, improving the resilience of the service and the attractiveness of the post to potential new recruits. Additionally, there may be no need for an on-call CT radiographer service on the planned care site, which would alleviate some of the pressure of competition from private providers for this workforce group.

This service model would give rise to the opportunity for staff to be trained to work across a number of areas such as plain X-Ray and acute head scanning, which would provide broader development opportunities for staff and thereby improve recruitment and retention.

8.5.3 Wider workforce initiatives

This section sets out the broader initiatives the Trust will employ over the five year period to improve the quality and resilience of clinical services, improve opportunities for workforce and to respond to the financial challenges facing the Trust.

- **Pennine GP Alliance:** exploring new initiatives for the delivery of community services in collaboration with Pennine GP Alliance.
- **West Yorkshire's Association of Acute Trusts**: exploring the pooling / sharing Radiology on call with West Yorkshire's Association of Acute Trusts to improve service delivery resilience, efficient deployment of limited resources across the patch and mitigating recruitment challenges in the face of National shortages Radiologists.
- **Workforce skill mix changes**: an example includes exploring the benefits and opportunities for improvements in quality of care through the use of Physician Associates and Advanced Nurse Practitioners.
- **West Yorkshire Urgent and Emergency Care Vanguard**: exploring opportunities to manage the increases in acute demand through alternative pathways
- **Shared provision of pathology service**: exploring opportunities to increase collaboration across the local pathology network to improve effective deployment of resources across the patch.
- **Primary care collaboration and integration:** enhancing generalist and collaborative skills for the Trust's workforce across primary and secondary care to support delivery of Commissioner QIPP requirements, and effective, efficient delivery of care closer to home for patients across the patch.
- **New ways of providing patient care:** exploring new methods of delivering patient services, for example the potential to use group clinics for appropriate services where this is anticipated to improve the effectiveness of resource deployment whilst maintaining or improving service quality.
- **Sickness absence:** employing initiatives to better managing long and short term sickness absence across the Trust.
- **Use of technology:** employment of IT solutions to improve patient care and better enable self-management of care for patients, whilst reducing clinics and travel time for the Trust's workforce, for example Telehealth, virtual clinics. Telehealth for patients with long-term conditions for example could improve regularity of monitoring conditions allowing prompt detection of any deterioration and thus a swifter response by clinicians. Another example is the use of Telehealth to link services between different care settings, or to bringing specialist care closer to the community.

The Trust is committed to developing a comprehensive Workforce Strategy following completion of the 5 Year Strategic Plan.

The Trust acknowledges the need for prioritising the development of a Workforce Strategy to explore, prioritise, plan, deliver and take advantage of the above workforce initiatives.

8.5.4 The Workforce Plan

The workforce plan sets out the impact of the Five Year Strategic Plan on workforce numbers by staff group and highlights the factors contributing to the overall changes in whole time equivalents (WTEs).

Staff WTEs are anticipated to reduce by 966 (17%) over the period to FY22, from 5,597 in FY17 to 4,631. This equates to an average annual reduction of 3.2%.

Type	Category	16/17	17/18	18/19	19/20	20/21	21/22	% change
Substantive	Consultant	235	238	240	245	245	242	3%
Substantive	Junior medical	310	321	329	337	348	336	8%
Substantive	Non clinical staff	1,054	1,002	950	899	854	792	(25%)
Substantive	Nursing, midwifery & health visitors - community*	294	294	294	294	294	295	0%
Substantive	Nursing, midwifery & health visitors - inpatient*	2,312	2,300	2,300	2,319	2,305	2,224	(4%)
Substantive	Scientific, therapeutic, & technical	865	821	782	744	700	657	(24%)
Substantive	General practitioners		-	-	-	-	4	-
Agency & Locum	Consultant	22	16	11	5	5	4	(82%)
Agency & Locum	Junior medical	55	45	35	19	9	8	(86%)
Agency & Locum	Non clinical staff	326	271	218	164	109	54	(83%)
Agency & Locum	Nursing, midwifery & health visitors	123	100	79	57	34	14	(89%)
Agency & Locum	Scientific, therapeutic, & technical	1	1	1	1	1	1	(13%)
Total		**5,597**	**5,409**	**5,238**	**5,084**	**4,905**	**4,631**	**(17%)**

**includes advanced practitioners*

Table 80: Forecast configuration of workforce

The above workforce numbers reflect the following factors:

- There is a planned shift from agency and locum staff to substantive staff, phased into the plan over the forecast period. This is delivered through CIPs and enabled by the reconfiguration of services across sites.
- Consultant staff numbers are disproportionately not impacted by the Trust requirement to deliver annual CIPs and the reconfiguration of clinical services, with a reduction of 4% WTEs over the forecast period.
- Similarly, junior medical doctors are disproportionally not impacted by CIPs and the reconfiguration, with a reduction of 6% over the forecast period.

- The medical staff reductions of 4% and 6% are in the context of forecast activity reductions of 12% in the plan relating to the Commissioner QIPP, exceeding forecast growth.
- Community nursing, midwifery and health visitor numbers remain roughly constant through the period reflecting the Trust's strategic priority to deliver care closer to home according to the principles set out 'Right Care, Right Time, Right Place' (no assumption has been made as to whether the Trust will be the provider of choice for community services going forwards).
- Across the nursing workforce as a whole there is a 7% reduction of in WTEs. The majority of this (61%) relates to the requirement of the Trust to deliver CIPs.
- Non clinical staff are impacted more significantly than clinical staff with regards to delivery of annual CIPs, reflecting the Trust's intention to protect front line clinical services and workforce to the greatest possible extent.

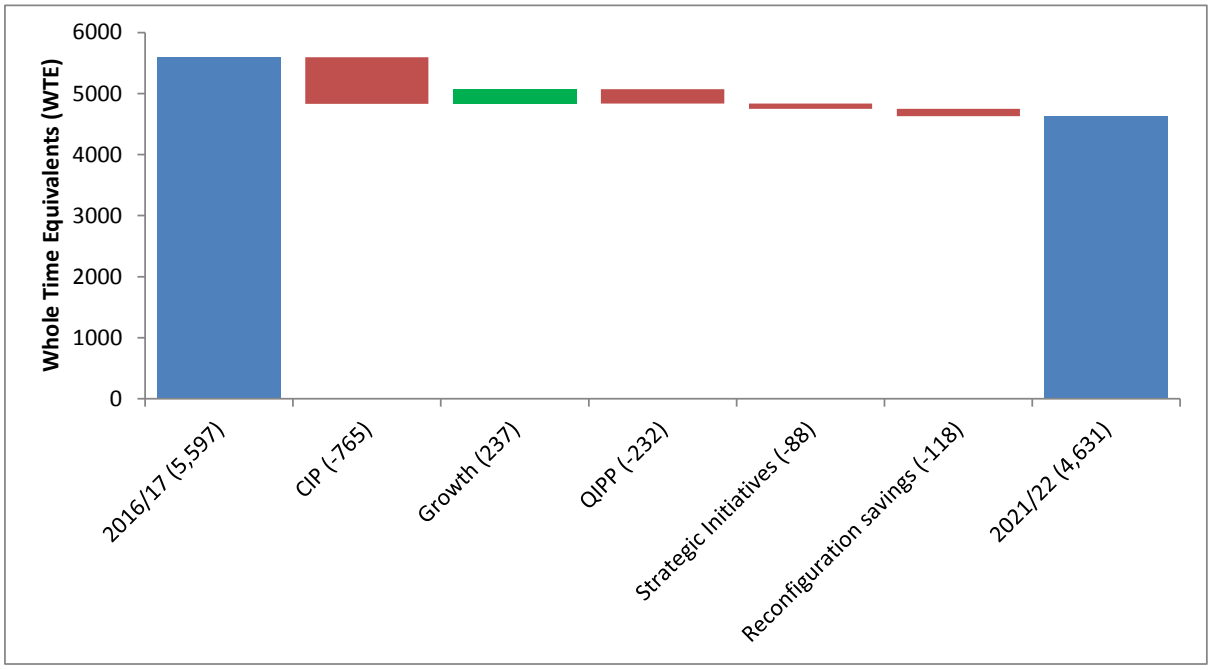


Table 81: Reductions in WTEs bridge

The above bridge shows the contributing factors behind the 966 reduction in WTEs.

Of the total reduction in workforce of 966 WTEs, 765 (79%) relates to delivering the annual efficiency requirement, 88 (9%) relates to non-configuration dependent strategic savings and 122 (13%) relates to delivering further savings associated with the proposed clinical reconfiguration.

The impact of Commissioner QIPP reductions in acute hospital demand and the impact of demographic and non-demographic growth in demand approximately net off with regards to overall workforce numbers, with a net increase of five.

It is noted that the workforce requirements relating to delivering the reconfiguration of clinical services (e.g. including double running costs) are non-recurrent, and as such do not contribute to the overall movement in WTEs between FY17 and FY22.

No redundancy costs have been included in reconfiguration costs in the financial case, despite the projected reduction in WTEs arising from the reconfiguration. Instead it is assumed that business as usual turnover of staff, currently at 15.4%, will be sufficient to achieve the necessary reduction in WTEs without the need for redundancies.

9. Key risks to the future case

The Five Year Strategy is subject to a number of significant risks.

- Key risks include:
  - **Failure to have sufficient capacity to meet demand.** This is likely to be due to under delivery of forecast QIPP, and/or greater than anticipated growth in non-elective demand. It would be likely to lead to significant operational, financial and clinical pressures**.**
  - **Failure to deliver savings in excess of business as usual CIP savings requirements.** There is also the risk of additional costs being incurred, particularly in relation to 7-day working requirements.
  - **Failure to reach a satisfactory agreement with the current CRH PFI provider on the proposed estate changes.** An agreement will be necessary prior to any changes to CRH being made. The current financial forecasts do not include any incremental costs which may be associated with implementation at the CRH PFI site. This will be subject of negotiations with the current PFI provider.
  - **Failure to secure the proposed capital and transitional funding.** This may make the proposed reconfiguration become unaffordable.
- **Development of mitigations to address these risks is ongoing.**
- **A comprehensive risk assessment, escalation and mitigation process is in place to support the plan**. Risks are managed centrally through the Project Team, and locally through the sub-groups reporting into the Project Team with escalation to corporate level in accordance with agreed thresholds.

9.1 Risk identification, classification, reporting and escalation

The CHFT corporate risk scale has been used to assess the risk severity factor. This is provided below:

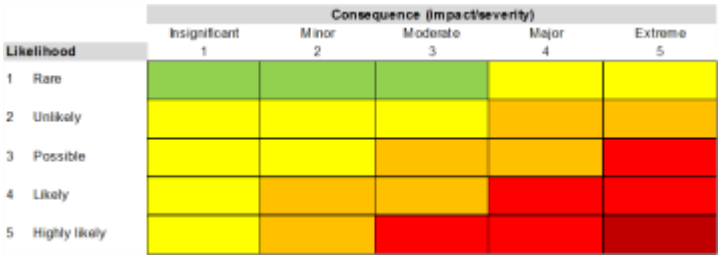


Figure 39: CHFT corporate risk matrix

A programme risk register has been created and is managed centrally through the Project Team, and locally through the sub-groups reporting into the Project Team. When identified, each risk is described in the risk register and allocated a reference number. The risk is assigned an owner and scored 1-5 in terms of its likelihood and the severity of its consequences.

Once a risk has been scored, the controls available are analysed and a mitigation owner is identified. Actions required to mitigate the risk are identified in the risk register, with responsible officers

identified and information on progress. A residual score is also included, showing how progress on mitigation has affected the level of risk.

On a monthly basis the Risk and Compliance Group considers all risks that potentially may be deemed a corporate risk. All programme risks with a risk score of 15 or more (calculated by multiplying likelihood by consequence) are escalated to corporate risk level and are subsequently included on the Corporate Risk Register (CRR).

The CRR is presented to the Board on a monthly basis to ensure that the Board is aware of all current key risks facing the Trust and is a key part of the Trust's risk management system.

The role of the Board is to assure itself that all risks are accurately identified and mitigated adequately by reviewing the risks identified on the CRR

In the programme risk register, risks are identified according to the following categories:

- Clinical & Operational
- Financial
- Workforce
- Commercial
- Communications
- CIP delivery

9.2 Key programme risks

The key risks identified in the programme risk register are:

9.2.1 Demand and capacity

The model assumes delivery of a significant level of QIPP - a 6% per year reduction in non-elective medical activity. This impacts on forecast bed requirements, with a reduction of 125 beds from the bed base over the 5 year time horizon of the forecast assumed in the model (N.B. this is off-set by growth to yield a net 78 bed reduction from a combination of QIPP and demographic growth). Under-delivery of QIPP risks leaving the Trust with insufficient beds to address demand, which is likely to lead to significant operational, financial and clinical pressures.

9.2.2 Savings and cost pressures

The financial plan assumes delivery of significant savings over and above business as usual CIP savings. In particular, a 2% improvement in workforce efficiency is assumed. This is reliant on implementing bold initiatives, and significant work will need to be undertaken to develop and implement these savings opportunities. The Trust is at risk of incurring significant additional cost pressures, including from 7-day working requirements. There is a risk of wider system cost pressures crystallising, for example from the Yorkshire Ambulance Service.

9.2.3 PFI limitations

Any changes to CRH will need to be agreed with the current PFI provider, and will therefore be subject to negotiation and agreement with them. This risks directly hindering the proposed plans, or may result in increased capital and/or revenue costs being incurred for implementation.

9.2.4 Capital availability

There is a macro-level risk that there will be insufficient capital funding available to support the proposed investment, and/or it will not be deemed affordable.

9.3 Risk register

Workstream	Risk Description	Likelihood (1-5)	Impact (1-5)	Risk Factor	Mitigating action
Clinical and Operational	Decrease in quality of patient experience and increase in waiting times due to insufficient acute capacity to support levels of demand.	4	5	20	Through the planning process: Tracking of existing planned QIPP schemes and impact on activity. Service planning refinement with the commissioners as part of development of outline and full capital business cases. Following implementation of the new model: Divert to alternative qualified providers to handle immediate pressures, coupled with development of a strategic plan to address the demand - either through further activity reduction measures and/or creation of additional capacity.
Financial	Potential to expand CRH to accommodate more capacity may be constrained by the terms of the PFI agreement.	3	5	15	Early and continued engagement with PFI provider. Clarity that CHFT has other build and strategic options to take forward.
Financial	Capacity is limited given the decision to run 732 beds. The Trust is reliant upon CCGs managing admissions within known capacity and effective use of care closer to home.	3	5	15	Stakeholder engagement plans include engagement with CCGs. The Trust will continually engage with its commissioners to ensure that, working in partnership, demand can be appropriately managed within the Trust's capacity and the CCGs can ensure equitable access to care
Financial	There is insufficient funding available to facilitate the implementation of any service reconfigurations.	3	5	15	The Trust will most likely complete an Outline Business Case to finally determine its preferred capital option and a Full Business Case to underline the final benefits from the chosen capital programme. These will be shared with DH who will most likely provide feedback from Treasury, allowing the Trust maximum opportunity to secure the required funding to implement the reconfiguration of services.

Financial	There is a risk that NHS England will not provide the transitional funding required to support reconfiguration	3	5	15	Regular communication and negotiation with NHS England and the DH is needed in order to ensure there is a clear articulation of the long term benefits of the case and obtain the funding required.
Financial	Risk of implementation of strategic initiatives and reconfiguration being delayed, resulting in improvements to the Trust's financial position taking longer than anticipated. This could jeopardise the Trust's cash position if it is significantly at variance with the planned PDC support agreed with the centre.	3	5	15	Robust programme, project and benefits management will be required to ensure that savings are being delivered on schedule. Implementation plans have been developed to facilitate robust management of schemes.
Clinical and Operational	Decrease in quality of patient experience and increase in waiting times due to insufficient acute capacity, as a result of changes in wider system social and community care provision that increase acute demand.	3	4	12	Through the planning process: Capacity refinement with local authority input as part of the development of outline and full capital business cases. Following implementation of the new model: Divert to additional providers to handle immediate pressures, coupled with development of a strategic plan to address the demand - either through further activity reduction measures and/or creation of additional capacity.
Clinical and Operational	Non-elective growth exceeds forecast expectations resulting in increased pressure on capacity and negatively impacting upon QIPP.	3	4	12	Growth in non-elective demand to be mitigated by Commissioners as part of QIPP scheme expansion.
Workforce	Workforce capacity challenges during implementation of the reconfiguration programme, leading to a protracted period of implementation and greater than anticipated double running costs	3	4	12	Robust project planning of the reconfiguration implementation, planned suitably in advance and demonstrating a suitable level of assurance over the mitigation of workforce capacity related risks. This plan will need to determine the most appropriate phasing of the reconfiguration to minimise operational, workforce, clinical and financial risks.

Workforce	Incomplete delivery of the proposed workforce changes necessary to deliver reconfiguration and other strategic initiative benefits	2	5	10	A robust Workforce Strategy is required to provide an appropriate level of granularity to all proposed workforce related changes required over the period. This will need to demonstrate a suitable level assurance over the deliverability of the strategy - such as including details of the governance process and stakeholder communications programme that will underpin this.
Workforce	Risk of inability to staff urgent care centres with sufficient GPs	4	2	8	Close working with commissioners and local GP federations coupled with a recruitment drive to identify the necessary resource

10. Appendices

10.1 Comparison of options against the Do Nothing position

This section bridges each option's I&E and cash position from the Do Nothing position. This enables a greater understanding of the drivers of the position within each option.

10.1.1 Do Nothing option to Strategic Initiative Savings only option

	I&E							CASH						
£m	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Do Nothing option	**(21.1)**	**(33.0)**	**(27.5)**	**(28.5)**	**(30.4)**	**(30.9)**	**(31.2)**	**(11.0)**	**(47.9)**	**(83.0)**	**(115.6)**	**(151.0)**	**(183.7)**	**(217.0)**
Capital expenditure (Backlog only)	—	—	—	—	—	—	—	—	(18.5)	(32.2)	(44.1)	(55.9)	(74.7)	(74.7)
- Depreciation	—	(0.6)	(1.2)	(1.9)	(2.6)	(3.3)	(3.3)	—	—	—	—	—	—	—
- Impairment	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Profit/(loss) on disposal of assets	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Disposal cash proceeds	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Loan Drawdown	—	—	—	—	—	—	—	—	18.5	37.0	55.4	73.9	92.4	92.4
- Interest	—	(0.2)	(0.7)	(1.3)	(1.7)	(2.1)	(2.0)	0.0	(0.2)	(0.9)	(2.2)	(3.9)	(6.0)	(8.0)
- Principal repayment	—	—	—	—	—	—	—	—	—	—	—	(3.7)	(7.4)	(11.1)
PDC dividend	—	(0.7)	0.1	0.4	0.6	0.7	0.7	—	(0.7)	(0.6)	(0.2)	0.4	1.1	1.8
Interest received/(paid) on cash balances	—	(0.0)	0.1	0.3	0.6	0.8	0.9	—	(0.0)	0.1	0.4	1.0	1.8	2.8
Working capital movement	—	—	—	—	—	—	—	—	—	0.0	(0.2)	(0.3)	(0.3)	(0.3)
Strategic initiatives savings (excluding reconfiguration)	—	—	1.1	3.6	7.0	7.1	7.4	—	—	1.1	4.7	11.7	18.8	26.2
Strategic Initiatives Savings only position	**(21.1)**	**(34.6)**	**(28.1)**	**(27.4)**	**(26.4)**	**(27.6)**	**(27.5)**	**(11.0)**	**(48.9)**	**(78.6)**	**(101.7)**	**(127.8)**	**(158.0)**	**(188.0)**

Table 82: I&E and Cash bridges from Do Nothing option to Strategic Initiatives Savings option

10.1.2 Do Nothing option to HRI as the site for unplanned care option

	I&E							CASH						
£m	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY16	FY17	FY18	FY19	FY20	FY21	FY22
Do Nothing option	**(21.1)**	**(33.0)**	**(27.5)**	**(28.5)**	**(30.4)**	**(30.9)**	**(31.2)**	**(11.0)**	**(47.9)**	**(83.0)**	**(115.6)**	**(151.0)**	**(183.7)**	**(217.0)**
Capital expenditure	—	—	—	—	—	—	—	—	(46.2)	(134.1)	(220.1)	(283.0)	(283.3)	(283.3)
- Depreciation	—	(1.5)	(2.3)	(3.1)	(5.4)	(7.7)	(7.8)	—	—	—	—	—	—	—
- Impairment	—	—	—	—	(31.3)	—	—	—	—	—	—	—	—	—
PFI soft FM reduction	—	—	—	—	—	—	—	—	—	—	—	—	—	—
PFI utilities reduction	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Profit/(loss) on disposal of assets	—	—	—	—	—	—	4.5	—	—	—	—	—	—	4.5
Disposal cash proceeds	—	—	—	—	—	—	1.1	—	—	—	—	—	—	1.1
Loan Drawdown	—	—	—	—	—	—	—	—	46.2	138.9	231.5	301.1	301.1	301.1
- Interest	—	(0.6)	(2.3)	(5.4)	(7.1)	(6.8)	(6.5)	0.0	(0.6)	(2.9)	(8.3)	(15.4)	(22.2)	(28.7)
- Principal repayment	—	—	—	—	—	—	—	—	—	—	—	(12.0)	(24.1)	(36.1)
PDC dividend	—	(0.7)	0.2	0.5	1.2	1.6	1.5	—	(0.7)	(0.5)	(0.1)	1.1	2.8	4.3
Interest received/(paid) on cash balances	—	0.0	0.0	0.3	0.4	0.3	0.3	—	0.0	0.1	0.3	0.8	1.0	1.3
Working capital movement	—	—	—	—	—	—	—	—	—	0.0	(0.2)	(0.3)	(0.1)	(1.1)
Strategic initiatives savings (excluding reconfiguration)	—	—	1.1	3.6	7.0	7.1	7.4	—	—	1.1	4.7	11.7	18.8	26.2
Site Reconfiguration savings	—	—	1.3	3.5	5.8	7,4	9.1	—	—	1.3	4.8	10.6	17.7	27.6
HRI as the site for unplanned care position	**(21.1)**	**(35.8)**	**(29.5)**	**(29.2)**	**(59.8)**	**(29.0)**	**(21.6)**	**(11.0)**	**(49.2)**	**(79.2)**	**(102.9)**	**(136.5)**	**(172.1)**	**(200.2)**

Table 83: I&E and Cash bridges from Do Nothing option to HRI as the site delivering unplanned care option

10.1.3 Do Nothing option to CRH as the site for unplanned care

	I&E							CASH						
£m	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**
Base case	**(21.1)**	**(33.0)**	**(27.5)**	**(28.5)**	**(30.4)**	**(30.9)**	**(31.2)**	**(11.0)**	**(47.9)**	**(83.0)**	**(115.6)**	**(151.0)**	**(183.7)**	**(217.0)**
Capital expenditure	—	—	—	—	—	—	—	—	(15.5)	(102.7)	(187.9)	(273.1)	(273.4)	(273.4)
- Depreciation	—	(5.2)	(8.6)	(5.2)	(3.0)	(2.9)	(3.0)	—	—	—	—	—	—	—
- Impairment	—	—	—	—	(41.4)	—	—	—	—	—	—	—	—	—
Profit/(loss) on disposal of assets	—	—	—	—	—	(58.3)	—	—	—	—	—	—	—	—
Disposal cash proceeds	—	—	—	—	—	—	—	—	—	—	—	—	7.0	7.0
Loan Drawdown	—	—	—	—	—	—	—	—	15.5	107.4	199.3	291.2	291.2	291.2
- Interest	—	(0.2)	(1.5)	(4.7)	(6.8)	(6.6)	(6.3)	—	(0.2)	(1.7)	(6.4)	(13.3)	(19.8)	(26.1)
- Principal repayment	—	—	—	—	—	—	—	—	—	—	—	(11.6)	(23.3)	(34.9)
PDC dividend	—	(0.7)	0.4	0.9	1.7	3.7	4.8	—	(0.7)	(0.2)	0.6	2.4	6.1	10.9
Interest received/(paid) on cash balances	—	0.0	0.1	0.3	0.5	0.6	0.8	—	0.0	0.1	0.4	1.0	1.5	2.3
Working capital movement	—	—	—	—	—	—	—	—	—	0.0	(0.2)	(0.4)	(0.4)	(0.7)
Strategic initiatives savings (excluding reconfiguration)	—	—	1.1	3.6	7.0	7.1	7.4	—	—	1.1	4.7	11.7	18.8	26.2
Site Reconfiguration savings	—	—	1.3	3.5	5.8	7.4	18.0	—	—	1.3	4.8	10.6	18.0	36.0
CRH as the site for unplanned care position	**(21.1)**	**(39.0)**	**(34.8)**	**(30.1)**	**(66.5)**	**(79.9)**	**(9.5)**	**(11.0)**	**(48.7)**	**(77.7)**	**(100.2)**	**(132.6)**	**(158.1)**	**(178.6)**

Table 84: I&E and Cash bridges from Do Nothing option to CRH as the site delivering unplanned care option

10.2 Funding

This section provides greater detail on the Trust's funding requirement across the years FY17 to FY22 under each option.

- **Existing capital funding –** this is funding for the Trust's existing capital programme of backlog maintenance. No funding has been assumed within the financial modelling;
- **Investment in the PMU –** the Trust has an existing commercial venture which requires capital investment that provides a strong return. No funding has been assumed within the financial modelling;
- **Reconfiguration capital funding –** this represents the capital outlays required to deliver the interventions mandated within each option. This has been included in the financial modelling as being financed by an ITFF loan;
- **PFI capital funding –** relates to capital expenditure on PFI lifecycle assets. No funding has been assumed within the financial modelling;
- **Liquidity support funding –** this is funding specifically to support the Trust's I&E position and the resultant cash shortfall;
- **Revenue reconfiguration costs –** this relates to the revenue costs associated with the reconfiguration of services (e.g. project management support, double running costs during transfer of services). This funding is in the form of non-recurrent income

10.2.1 Do Nothing option

The total funding requirement under the Do Nothing option is £217.0m. Of this amount, £81.3m is sourced from ITFF loans and the remaining £135.7m is from PDC support.

£m	FY17	FY18	FY19	FY20	FY21	FY22	TOTAL	*Source*
Existing capital programme funding	14.3	12.3	11.3	13.5	10.2	10.2	**71.7**	*ITFF Loan*
Investment in PMU	-	-	-	-	-	-	**-**	
Reconfiguration capital funding	-	-	-	-	-	-	**-**	
PFI capital funding	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**	*ITFF Loan*
Liquidity support funding	32.1	21.2	19.8	20.3	20.9	21.4	**135.8**	*Cash/PDC*
Reconfiguration cost support	-	-	-	-	-	-	**-**	
TOTAL	**47.9**	**35.1**	**32.6**	**35.4**	**32.8**	**33.3**	**217.0**	

Table 85: Funding requirement under Do Nothing option

The total funding requirement for the Strategic Initiatives Savings option is £280.4m. Of this amount, £156.0m is sourced from ITFF loans and the remaining £124.4m is from PDC support.

£m	FY17	FY18	FY19	FY20	FY21	FY22	TOTAL	*Source*
Existing capital programme funding	14.3	7.4	4.3	6.5	10.2	10.2	**52.8**	*ITFF Loan*
Investment in PMU	-	0.3	0.3	0.3	0.3	-	**1.2**	*ITFF Loan*
Reconfiguration capital funding	18.5	18.5	18.5	18.5	18.5	-	**92.4**	*ITFF Loan*
PFI capital funding	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**	*ITFF Loan*
Liquidity support funding	33.2	20.5	17.0	17.6	18.1	18.1	**124.4**	*Cash/PDC*
Revenue reconfiguration costs	-	-	-	-	-	-	**-**	
TOTAL	**67.4**	**48.2**	**41.6**	**44.6**	**48.7**	**30.0**	**280.4**	

Table 86: Funding requirement under Strategic Initiative Savings only option

10.2.2 HRI as the site for unplanned care

If HRI were to be the site delivering unplanned care, the total funding requirement increases to £509.1m. Of this amount, £364.7m has been identified as being from ITFF loans and £136.6m of liquidity support in the form of PDC. Funding to support the revenue costs of the reconfiguration amounts to £7.8m and is sourced from commissioners/NHS England as non-recurrent income.

£m	FY17	FY18	FY19	FY20	FY21	FY22	TOTAL	*Source*
Existing capital programme funding	14.3	7.4	4.3	6.5	10.2	10.2	**52.8**	*ITFF Loan*
Investment in PMU	-	0.3	0.3	0.3	0.3	-	**1.2**	*ITFF Loan*
Reconfiguration capital funding	46.2	92.7	92.7	69.6	-	-	**301.1**	*ITFF Loan*
PFI capital funding	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**	*ITFF Loan*
Liquidity support funding	33.5	20.8	17.6	25.2	23.4	16.3	**136.6**	*Cash/PDC*
Revenue reconfiguration costs	-	0.3	0.5	1.1	5.7	0.2	**7.8**	*Commissioners / NHS England*
TOTAL	**95.4**	**122.9**	**116.9**	**104.3**	**41.2**	**28.4**	**509.1**	

Table 87: Funding requirement under the HRI as the site for unplanned care option

10.2.3 CRH as the site for unplanned care

When CRH is used as the site for delivering unplanned care, the total funding requirement is £478.8m. This is £30.3m less than HRI being the site for unplanned care.

The ITFF debt requirement is £354.8m and cash support amounts to £115m. Funding to support the revenue costs of the reconfiguration amounts to £9.1m of non-recurrent income from commissioners/NHS England.

£m	FY17	FY18	FY19	FY20	FY21	FY22	TOTAL	*Source*
Existing capital programme funding	14.3	7.4	4.3	6.5	10.2	10.2	**52.8**	*ITFF Loan*
Investment in PMU	-	0.3	0.3	0.3	0.3	-	**1.2**	*ITFF Loan*
Reconfiguration capital funding	15.5	91.9	91.9	91.9	-	-	**291.2**	*ITFF Loan*
PFI capital funding	1.5	1.5	1.6	1.7	1.7	1.7	**9.6**	*ITFF Loan*
Liquidity support funding	33.0	19.8	16.4	23.9	13.3	8.7	**115.0**	*Cash/PDC*
Revenue reconfiguration costs	-	0.3	0.5	1.1	6.9	0.2	**9.1**	*Commissioners / NHS England*
TOTAL	**64.2**	**121.2**	**115.0**	**125.3**	**32.4**	**20.7**	**478.8**	

Table 88: Funding requirement under the CRH as the site for unplanned care option

10.3 Clinical Consensus Model

Hospital services
Future Model of Care

10.4 Long list of strategic initiatives

		Area	Option
A		**Internal rebalancing**	***1. Reconfiguration of hospital services*** 2. Further service line review to assess profitability / viability by service and make decisions on divestment or growth opportunity 3. Procurement collaboration at scale to optimise purchaser power to ensure VFM (Carter Review) 4. Management infrastructure collaboration – shared back office and leadership roles across acute providers and potentially with primary care ***5. Identification of service development opportunities to ensure we maximise income for the Trust***
B		**Improving Quality**	***6. Deliver best in class LOS, DNAs, New to FU ratios and ambulatory care – optimise performance to reduce waste and enable bed reduction*** ***7. Address clinical variation ensuring delivery of consistent standardised evidence based care*** ***8. Optimise 7-day working within resources*** ***9. Optimise community service model to reduce demand on hospital, incorporating gain-share e.g. – diabetes, respiratory, frailty, paediatrics***
C		**Improving Productivity**	***10. Workforce and skills planning*** a. ***Trust skill mix and workforce plan*** b. ***Integrated multi-disciplinary approaches to care*** c. ***Volunteers and 3rd sector*** 11. Workforce planning skill mix – new skill mix models with increased role of generalists 12. Theatre productivity – learning from 'assembly line' approaches to surgery provision from elsewhere ***13. Reduce Bank and Agency use and deliver sustainable sickness absence reduction*** ***14. Enhancing productivity of community work*** ***15. Optimise information technology benefits*** 16. Increase the use of group interventions where appropriate. 17. Enhance the use of Peer Support workers and voluntary workforce to support LTC management

			and reduce workforce costs. 18. Optimise diagnostic tests eliminating waste 19. Explore one 'stop shop' models for MSK/orthopaedics, pain management, rheumatology 20. Review drugs and pharmacy spend 21. Terms and conditions review
D		**Rebalancing service portfolio via mergers and partnerships**	***22. Reduce hospital and community demand by increasing prevention and self-care support for population*** 23. Acute Vanguard – collaborate with WY Trusts ***24. MCP Vanguard – New Care Models that offer integrated community, primary and acute care*** 25. Care Homes collaboration to reduce demand on hospital 26. Strategic estate review to rationalise and reduce estate cost. ***27. Strategic partnerships (e.g. with GP Federations, voluntary sector, other organisations)***
E		**Significant longer term investments**	28. PMU expansion and development 29. New commercial venture such as private patient wing 30. Invest in research capability with aim of securing longer revenue benefit of research funding 34. Develop capacity to market services internationally
F		**Investment in strategic enablers**	***35. Investment in service improvement capability such as Lean and developing Fellowships with IHI / Kings Fund/ Birmingham University*** 35. Contract with AQUA or Quest 36. Invest in informatics and analytical capacity 37. Invest in technology - EPR already agreed is there anything further? 38. Invest in workforce planning capability and capacity 39. Invest in building voluntary sector partnerships and capacity ***40. Introduce innovative finance structures that enable savings***

10.5 Key information to support Clinical Case

Site	Specialty	Day case	Elective	Non-Elective	Critical Care	Total
CRH	GENERAL SURGERY	0	3	41	0	45
	UROLOGY	0	7	14	0	22
	VASCULAR SURGERY	0	2	8	0	11
	ORTHOPAEDIC SURGERY	0	3	32	0	35
	EAR NOSE AND THROAT	3	3	4	0	9
	OPHTHALMOLOGY	0	0	0	0	0
	MAXILLO FACIAL SURGERY	2	0	0	0	2
	PLASTIC SURGERY	0	0	0	0	0
	ACCIDENT & EMERGENCY	0	0	6	0	6
	CRITICAL CARE BEDS	0	0	0	18	18
	PAIN MANAGEMENT	0	0	0	0	0
	GENERAL MEDICINE	0	1	96	0	97
	GASTROENTEROLOGY	0	2	8	0	10
	ENDOCRINOLOGY	0	0	0	0	0
	HAEMATOLOGY	0	0	4	0	4
	HEPATOLOGY	0	1	8	0	9
	DIABETIC MEDICINE	0	0	0	0	0
	REHABILITATION	0	1	22	0	23
	PALLIATIVE MEDICINE	0	0	0	0	0
	CARDIOLOGY	0	2	31	0	33
	STROKE MEDICINE	0	0	8	0	8
	DERMATOLOGY	0	0	0	0	0
	RESPIRATORY MEDICINE	0	1	21	0	22
	GENITO-URINARY MEDICINE	0	0	0	0	0
	RENAL MEDICINE	0	0	0	0	0
	MEDICAL ONCOLOGY	0	1	10	0	11
	NEUROLOGY	0	0	1	0	2
	RHEUMATOLOGY	0	0	0	0	0
	PAEDIATRICS	0	0	39	0	39
	NICU	0	0	24	0	24
	ELDERLY	0	0	78	0	78
	OBSTETRICS	0	0	58	0	58
	GYNAECOLOGY	2	4	3	0	10
	MIDWIFERY	0	0	5	0	5
	MIDWIFERY PN	0	0	0	0	0
	INTERVENTIONAL RADIOLOGY	0	0	0	0	0
	WINTER PRESSURE BEDS	0	0	30	0	30
Total CRH		**8**	**31**	**554**	**18**	**612**

Table 89: Specialty-level beds at CRH if it is the unplanned care site

Site	Specialty	Day case	Elective	Non-Elective	Critical Care	Total
HRI	GENERAL SURGERY	15	17	9	0	41
	UROLOGY	4	1	4	0	9
	VASCULAR SURGERY	0	1	5	0	6
	ORTHOPAEDIC SURGERY	5	18	23	0	46
	OPHTHALMOLOGY	6	1	1	0	8
	MAXILLO FACIAL SURGERY	1	0	0	0	1
	PLASTIC SURGERY	2	0	0	0	2
	ACCIDENT & EMERGENCY	0	0	0	0	0
	ANAESTHETICS	0	0	0	0	0
	PAIN MANAGEMENT	3	0	0	0	3
	GENERAL MEDICINE	0	0	0	0	0
	GASTROENTEROLOGY	0	0	0	0	0
	REHABILITATION	0	0	0	0	0
	DERMATOLOGY	0	0	0	0	0
	RHEUMATOLOGY	0	0	0	0	0
	PAEDIATRICS	0	0	0	0	0
	ELDERLY	0	0	0	0	0
	OBSTETRICS	0	0	0	0	0
	GYNAECOLOGY	0	0	0	0	0
	MIDWIFERY	0	0	2	0	2
	MIDWIFERY PN	0	0	0	0	0
Total HRI		**36**	**38**	**46**	**0**	**120**

Table 90: Specialty-level beds if HRI is the planned care site

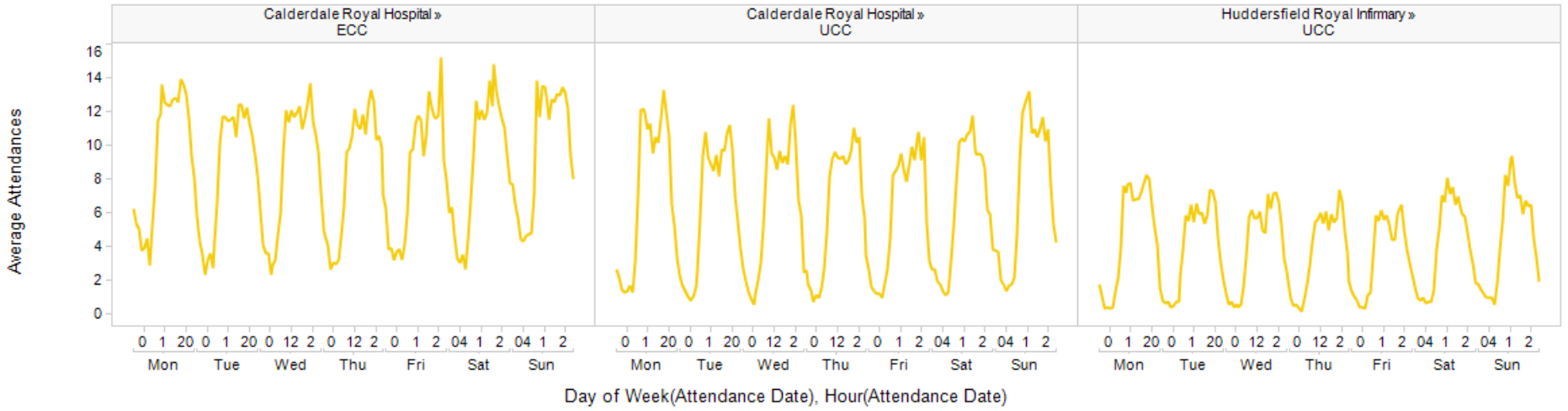


Figure 40: ECC and UCC attendance profiles if CRH is the unplanned care site

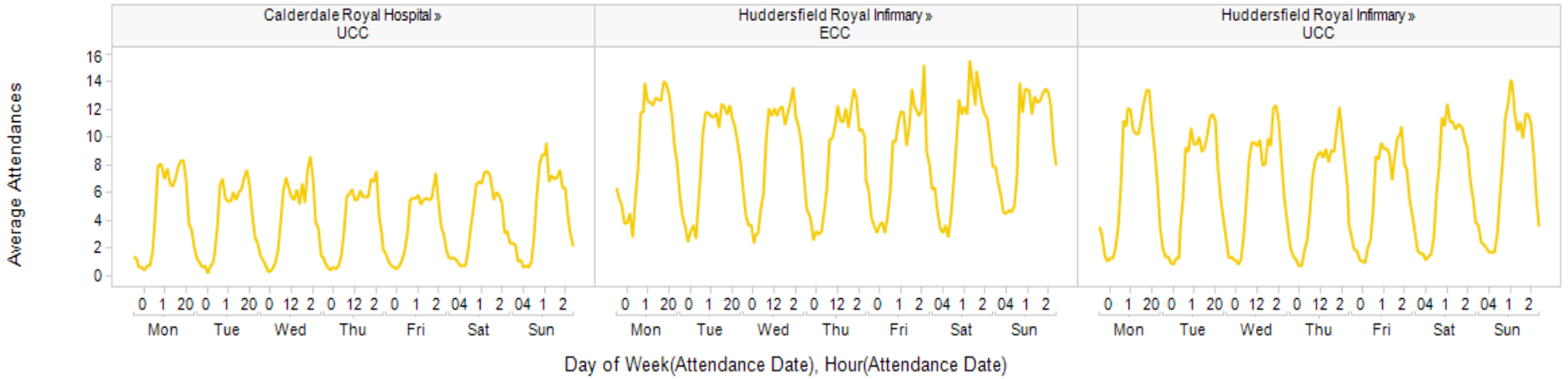


Figure 41: ECC/UCC attendance profiles if HRI is the unplanned care site

10.6 Current Medical Staffing in Key Areas Against FY17 Plan

Speciality	Staff	Actual	2016/17 Plan	Gap vs 16/17 Plan	RAG/Comments	Gap as Proportion of 16/17 Plan
Emergency Department	Consultants	9	12	3	All substantive staff, no agency staff	25%
	Junior Doctors	20.2	37.6	17.4	Currently 3.0 agency staff compared to 19.9 planned	46%
MAU	Consultants	7.5	11	3.5	Currently no agency staff compared to 3 planned	32%
	Junior Doctors	14.1	15.0	0.96	Currently 1.4 agency staff compared to 0.3 planned	6%
Geriatrics	Consultants	4.3	7.2	2.9	Currently 0.3 agency staff compared to 2.7 planned	41%
	Junior Doctors	18.7	20	1.3	Currently no agency staff compared to 1 planned	7%
Radiology	Consultants	16.2	16.3	0.1	Currently 1.7 agency staff compared to 0 planned	1%
	Junior Doctors	8.2	3.5	-4.7	Currently 7.3 agency staff compared to 0 planned	-137%
Medicine	Consultants	62.3	85.4	23.1	Currently 5.7 agency staff compared to 19.7 planned	27%
	Junior Doctors	144.6	162.8	18.3	Currently 26.2 agency staff compared to 34.8 planned	11%
FSS	Consultants	58.6	59.2	4.3	Currently 3.7 agency staff compared to 0 planned	7%
	Junior Doctors	67.7	57.5	-10.2	Currently 18.1 agency staff compared to 1 planned	-18%
Surgery	Consultants	93.8	106.5	12.7	Currently 2 agency staff compared to 1 planned	12%
	Junior Doctors	136.9	133.0	-3.8	Currently 29 agency staff compared to 0 planned	-3%

Table 91: Medical Staffing against plan FY17

10.7 Preferred site rationale: comparison between SOC, OBC and 5 year plan

SOC Rationale	5 Year Strategic Plan Rationale (i.e., what is different now and why?)
At the time of preparing this Strategic Outline Case the potential merits of topic 2 to secure longer term benefits, sustainability and value for money has been recognised by the Board of Calderdale and Huddersfield Foundation Trust. This preliminary view will be transparently and robustly tested through stakeholder engagement and public consultation – Page 58	The estate options facing the Trust have been tested against an agreed set of appraisal criteria (agreed with commissioners), underpinned by a number of critical success factors. This appraisal has identified that there is very little differential between Huddersfield or Calderdale as the preferred option for unplanned care, other than on financial grounds. In particular, the appraisal on clinical grounds has changed since the SOC as a result of the clinical model (and impact of the clinical model) being evaluated in more detail. On financial grounds therefore, Calderdale has been identified as the preferred site option for unplanned care, with Huddersfield as the preferred site option for planned care.

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
Number of Beds on the Planned and Unplanned Site Of the total bed number of **636** it has been determined that **85** beds will be required on the planned hospital site and **551** beds on the unplanned hospital site – page 130	• Total bed requirement now estimated at 732-734 beds (depending on the site option). • If CRH is unplanned 615 beds are required at Calderdale with 119 at Huddersfield. • If HRI is unplanned then 608 beds are required at Huddersfield with 126 beds at Calderdale. • These changes are in light of a much stronger understanding of, and agreement on, the clinical model between CHFT and the two commissioners, with updated activity modelling and a revised set of patient pathway assumptions. These assumptions have been based around balancing QIPP assumptions with building sufficient capacity into the future. • There is a small difference in the number of acute and elective beds required on each site depending on the choice of

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
	planned and unplanned care site. This is due to the modelled activity drift to other providers.
Total Reduction in Hospital Workforce Impact on WTE (reduction) / increase ***(409)*** - page 133	• Total reduction of 964 WTE. • This figure has been developed in alignment with the revised overall financial forecast for the Trust. • This takes account of CIP and QIPP, and no assumption for growth in community, whereas the OBC did assume an increase in community.
Estate requirement if **HRI or Acre Mills is the Planned Hospital Site.** An 85 bed planned unit. Possibly provided via a new development on the Acre Mill site and disposal of some parts of the existing site. The development would need to include theatres, a day case facility, diagnostic services, endoscopy, additional outpatient space, therapy services to support elective inpatient care, a birth centre, and a minor injuries unit. Reduction in total beds required on this site from circa 420 to 85 – page 139	• If HRI or Acre Mills is the planned hospital site, an estimated 119 bed unit will be required. • These changes are in light of updated activity modelling and a revised set of patient pathway assumptions. • The minor injuries unit is planned to be an urgent care centre. • This has been agreed as part of the Clinical Consensus Model. • The reduction in total bed required on this site is from c.420 to 119. • These changes are in light of a much stronger understanding of, and agreement on, the clinical model between CHFT and the two commissioners, with updated activity modelling and a revised set of patient pathway assumptions. These assumptions have been based around balancing QIPP assumptions with building sufficient capacity into the future.
Estate requirement if **CRH is the Planned Hospital Site**. A 85 bed planned unit. No additional estate works required. Reduction in total beds required on this site from circa 450 to 85. – page 139	• If CRH is the planned hospital site, the estimated bed requirement is 126. • Reduction in total beds required on this site is from c. 420 to 126. • No additional estate works required.
Estate requirement if **HRI is the Unplanned Hospital Site**. Upgrade of existing facilities related to recent 6 facet and asbestos surveys. A new ward block with circa 130 additional beds from 420 to total beds required approx. 551. A bigger Intensive Care Unit. An expanded A&E with a dedicated children's A&E.	• Lendlease Consulting Ltd has advised that if HRI is the unplanned site, an upgrade of existing facilities will be required with a new ward block to take total beds to c.608. • A bigger intensive care unit, an expanded A&E with a dedicated children's A&E and a new Women's and Children's unit will be required. There will be a reduction of two

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
A new Women's and Children's unit Additional day case theatres – page 139	theatres compared to the current 10. • These changes are in light of a much stronger understanding of, and agreement on, the clinical model between CHFT and the two commissioners, with updated activity modelling and a revised set of patient pathway assumptions. These assumptions have been based around balancing QIPP assumptions with building sufficient capacity into the future.
Estate requirement if **CRH is the Unplanned Hospital Site**. A new ward block with circa 100 additional beds from 450 to total beds required approx. 551. A bigger Intensive Care Unit that can deliver level 3 care. An expanded A&E, with a dedicated children's A&E. A multi-storey car park. Additional diagnostic services - including MRI and CT. Expanded pathology space – page 139	• If CRH is the unplanned site a new ward block to take total bed to c.615 will be required. • A bigger intensive care unit that can deliver level 3 care. An expanded A&E, with a dedicated children's A&E. • A multi-storey car park. Additional diagnostic services – including MRI and CT. • Expanded pathology space.
The majority of the Calderdale site is subject to a PFI agreement, however, should the Trust be able to undertake non PFI works, the site constraints mean that any capital cost at Calderdale could be higher than for corresponding works at Huddersfield – page 140	• A more comprehensive assessment of the capital costs at Calderdale has been undertaken by a third party – Lendlease Consulting Ltd. These cost estimates are still subject to a number of assumptions however including reaching agreements with the PFI provider. • However, CRH as the unplanned care site provides the option to gain sale proceeds from HRI to further reduce the ongoing debt of the local health economy.
The Calderdale site is a PFI site and any works within the area owned by the PFI Provider will be subject to their own procurement procedures which historically have taken longer and cost more. Within the PFI Contract there is an identifiable 12.5% overhead cost. The programme costs may also increase due to taking a longer period to procure the works. The type of subcontractors used may also lead to increased tender prices. Capital cost may therefore be higher at Calderdale than at	• A more comprehensive assessment of the capital costs at Calderdale has been undertaken by a third party – Lendlease Consulting Ltd. These cost estimates are still subject to a number of assumptions however including reaching agreements with the PFI provider. • A more comprehensive assessment of the lifecycle costs at Calderdale has been undertaken by a third party – Lendlease Consulting Ltd. This shows that revenue costs are reduced in either scenario but to a greater extent when CRH is the

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
Huddersfield. Should the works at Calderdale be then added to the annual PFI cost this will significantly increase the differential between Calderdale and Huddersfield when considered over the remaining 47 years of the PFI Contract. – page 140	unplanned care site. This protects resources for other healthcare needs. • Alternative funding options are being explored to use of the PFI.
Should the decision be made to locate the majority of the activity at Calderdale with a corresponding decrease in activity at Huddersfield, the following needs to be considered. Calderdale site is smaller than Huddersfield with little space for future development. It is unlikely that there is enough space currently available to allow decanting of departments to facilitate significant development, this means any development would need to be done on a piecemeal basis thus increasing cost. In reality it may mean needing to seek additional land adjacent to the site to facilitate future development. If Huddersfield became the planned site only, the activity currently forecast could be accommodated on the Acre Mill site thus allowing the Trust to exit the main HRI site with possible disposal. Should this happen there is little flexibility going forward in terms of decant space and ability to deliver new capital works. It would therefore seem prudent to retain the HRI site, however, this in itself has attendant backlog maintenance and other costs – page 140	• Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include; ○ Exploration of use of retained estate from the current CHFT build; ○ Use of Dryclough Close (estate on the CRH site owned outright by CHFT); ○ Increasing the number of vertical stories on the new build; ○ Multi-story car park development; and ○ Development on adjoining land. • These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere. • A more comprehensive assessment of the backlog maintenance and upgrade capital costs at HRI has been undertaken by a third party – Lendlease Consulting Ltd. This indicates that £92.4m would be required to upgrade time expired buildings at HRI.
The relocation of activity to Calderdale may result in a significant decrease in people choosing to access services at CHFT and more people choosing to go to Sheffield or Barnsley due to the demographics in South and East of Huddersfield. The ability at Calderdale to attract additional patients out with the current cohort is limited by the geography to the West of Calderdale and the location of other Trusts	• A more comprehensive analysis of activity drift based on patient travel time analysis has been undertaken. This shows that there is no significant decrease in people choosing to access services at CHFT irrespective of the choice of planned and unplanned site. This analysis is based on actual service user data to provide a robust basis for the analysis. Additional development, and the potential service use that may result from this, is captured

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
immediately to the East who currently attract activity away from Calderdale. Conversely development on the HRI site may mean patients to the North and East of Calderdale who currently use CHFT services may instead access provision from other Trusts. However this would be more than outweighed by the ability to draw in additional activity to HRI from Denby Dale, Holmfirth and the Penistone areas all of which under the new Government initiatives have plans for additional new homes in the near future. These factors are important to long-term viability – page 140.	within overall growth assumptions. However, the potential differential impact in Trust service demand from the potential location of different developments has not been included as it is necessarily highly speculative.
The relocation of activity to Calderdale will still mean unless HRI is sold the Trust has an on-going liability for the backlog maintenance at HRI. If capital projects are not forthcoming and patient activity at HRI is reducing the burden of the backlog maintenance on the Trust remains and a proportion of the income at Huddersfield is adversely impacted – page 140.	• This remains true, however, a valuation (including demolition costs) has been undertaken by a third party (Lendlease Consulting Ltd) as part of development of the 5 Year Plan and factored into the financial plan. • The plan assumes that part, or all, of the HRI site will be sold, minimising ongoing maintenance and upgrade requirements.
This should be similar across both sites, however, consideration needs to be given on the Calderdale site if the energy costs are paid through the PFI Contract. Whether the Trust have the same ability to renegotiate tariffs or agree savings which could be achieved on the HRI site – page 140.	• The service charges are renegotiated every three years. There is therefore scope to reduce energy costs and realise the savings. The assessment of the savings that can be realised at CRH has been factored into the financial appraisal.
Significant increase in activity at Calderdale may necessitate the need for additional land. Consideration was given over 10 years to acquiring the allotments, however, the costs at that time were prohibitive. Experience of negotiating with allotment holders on previous projects is laborious and disproportionately expensive. Conversely the HRI site has significant space for expansion and development of services. The site configuration also means new capital projects can be undertaken and delivered to allow services to	• Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include; ○ Exploration of use of retained estate from the current CHFT build; ○ Use of Dryclough Close (estate on the CRH site owned outright by CHFT); ○ Increasing the number of vertical stories on the new build; ○ Multi-story car park development; and ○ Development on adjoining land.

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
decant seamlessly from one building to another. This is not the case at Calderdale where it would have to be done in a piecemeal manner – page 141.	• These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere.
The patient pathways, staffing ratios and support services will be equal no matter which site the activity Is undertaken on. Therefore the key differentiator on clinical safety could be considered as the volume of activity needed to maintain a safe service due to the ability of the staff to maintain the necessary skill sets. The ability of the HRI site to attract additional activity is considered superior to that at the Calderdale site and therefore could be argued clinical safety and therefore patient outcomes would be better at HRI than at Calderdale – page 141.	• A more comprehensive analysis of activity drift to other providers based on patient travel time analysis has been undertaken. This shows that there is no material difference in the volumes of activity in either scenario.
The population served by Calderdale is less than that served by Huddersfield and whilst the transport links between the two hospitals are similar the reality of patients moving to one site or another means that the ability at HRI to attract more activity is considered better than at Calderdale for the reasons cited above. Consideration also needs to be given to the location of other A & E departments. The closure of A&E at HRI with a relocation of service to Calderdale would have a detrimental impact to the population south of the M62 whose closest A & E would currently be Dewsbury (which is earmarked for conversion to a Minor Injuries Unit) therefore leaving patients needing to travel to Wakefield, Barnsley or Sheffield. Consideration also needs to be given to the adjacency of the major arterial route of the M62. Any significant incident here would result in the most severely injured going to the major trauma centres, however the less severely injured would need	• Access to CRH from the motorway and Huddersfield is set to improve by 2021, with a significant investment in Halifax to Huddersfield A629 Corridor Improvements planned as part of a £1.4bn programme of transport improvements for West Yorkshire and York. • An analysis of activity drift to other providers based on patient travel time analysis has been undertaken. This shows that there is no material difference in the volumes of activity in either scenario. This is corroborated by analysis undertaken by the Yorkshire Ambulance Service on behalf of the commissioners showing that there is no material difference in average journey time in either scenario.

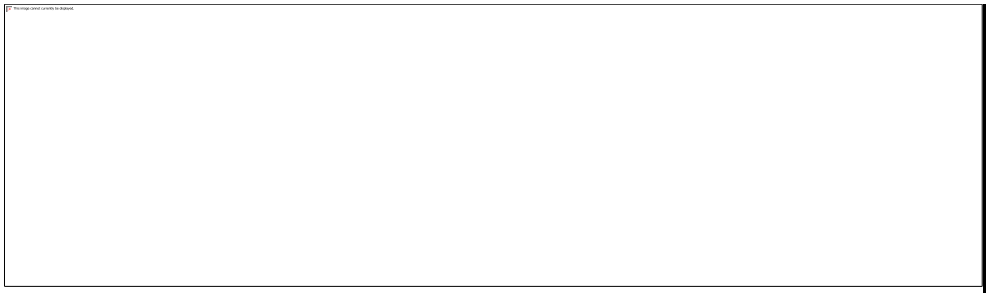
OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
to be accommodated in a local A & E and the communication link to HRI is superior to that to Calderdale – page 141.	
The current PFI arrangement at Calderdale limits the flexibility of the Trust to negotiate savings whereas activity at HRI can benefit directly from any cost savings the Trust are able to make – page 141.	• This point still stands. However, an estimate of the opportunity to make savings at CRH has been incorporated into the financial appraisal. This shows overall lower ongoing revenue costs where CRH is the unplanned care site, which protects resources for other healthcare needs.
The lack of flexibility of the PFI contract at Calderdale means the relocation of activity to HRI may incur less double running costs over a shorter period of time. The Trust have a proven track record of being able to deliver capital projects at HRI using traditional procurement routes much faster than has been the case through the PFI arrangement at Calderdale – page 141.	• Double running costs identified by divisions have shown no significant difference between the two site options. • Alternative funding options to the PFI are being explored. • CRH as the unplanned care site provides an opportunity to secure capital finance if capital funding is not available through the Department of Health.
Relocation of services from Calderdale to HRI may incur the Trust in one off staff relocation costs and may lead to some staff choosing to leave whose journey to work becomes significantly more difficulty. However a potential benefit of locating increased services at HRI is the larger population in the immediate vicinity and in the northern part of South Yorkshire which may provide an increased potential staff base and an advantage for workforce recruitment.	• Reconfiguration costs identified by the divisions have shown no significant difference between the two site options. • Staff relocation is anticipated to be equally challenging irrespective of the choice between the two site configuration options. • The Trust is already operating at HRI and is currently experiencing recruitment difficulties.
Selecting Calderdale as a primary site going forward for the reasons given above may seriously impair the ability to deliver a comprehensive long term service strategy due to the restrictions of the estates provision. The development of any future “specialisms” to attract activity from out with the immediate area would be limited by lack of available estate – page 141.	• Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include; ○ Exploration of use of retained estate from the current CHFT build; ○ Use of Dryclough Close (estate on the CRH site owned outright by CHFT); ○ Increasing the number of vertical stories on the new build; ○ Multi-story car park development;

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
	and ○ Development on adjoining land. • These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere.
Siting activity at HRI as stated elsewhere provides CHFT with a much larger demographic to use services going forward. Consideration also needs to be given to the creation of specialisms for drawing further activity. An example of this may well be at Calderdale where if this was the planned hospital this would not require use of the full estate and existing facilities. The current PFI Agreement means the Trust will still have to pay the PFI provider. The layout of the building and configuration of rooms at Calderdale may lend itself to alternative uses. Current demographics and the wider scale demand mean the current residential home provision in Calderdale is lacking as is the hospice provision. Calderdale hospital is ideally suited to meet such demand and could provide additional source of income as well as providing a much needed service to the wider population. There is potential to link up with other Care Home or Hospice providers in a joint venture – page 141.	• A more comprehensive analysis of activity drift based on patient travel time analysis has been undertaken. This shows that there is no significant decrease in people choosing to access services at CHFT irrespective of the choice of planned and unplanned site. • There is currently no specific opportunity to use CRH for alternative uses. The benefits of mothballing part of the CRH site (if it were to become the planned care site) have been incorporated into the financial appraisal. • The current financial situation of the NHS means that the Trust needs to be get best value from the PFI site. Use of CRH as the unplanned care site means that the PFI is being used to the maximum possible extent.
Assessment of option 3 against this criterion has raised a query as to whether this option could offer a deliverable and sustainable solution into the future. Section 8.4 describes the considerations that have informed this conclusion. This includes factors such as future development costs, size and future site flexibility, potential adverse population and income drift, speed of implementation – page 155.	• A more comprehensive assessment of the capital costs at Calderdale has been undertaken by a third party – Lendlease Consulting Ltd. These cost estimates are still subject to a number of assumptions however including reaching agreements with the PFI provider. • Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include; ○ Exploration of use of retained estate from the current CHFT build; ○ Use of Dryclough Close (estate on the CRH site owned outright by CHFT); ○ Increasing the number of vertical

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
	stories on the new build; ○ Multi-story car park development; and ○ Development on adjoining land. • These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere. • A more comprehensive analysis of activity drift based on patient travel time analysis has been undertaken. This shows that there is no significant decrease in people choosing to access services at CHFT irrespective of the choice of planned and unplanned site.
Assessment of option 3 against this criterion has raised a query as to whether this option does offer a long term strategic fit. Section 8.4 describes the considerations that have informed this conclusion. In particular the importance of the location of other A&E departments. The closure of A&E at HRI with a relocation of services to Halifax would have a detrimental impact to the population south of the M62. Consideration also needs to be given to the adjacency of the major arterial route of the M62. Any significant incident here would result in the most severely injured going to the major trauma centres, however the less severely injured would need to be accommodated in a local A&E and the communication link to HRI is superior to that to Calderdale. The Keogh Review of urgent and emergency services will lead to a reduction in the number of A&E departments in the future. It is likely that consolidation of A&E services in Huddersfield will offer a stronger geographical option than the provision of services in Halifax. Scenario 3 does reflect national policy direction of the Better Care Fund and the provision of	• An analysis of activity drift to other providers based on patient travel time analysis has been undertaken. This shows that there is no material difference in the volumes of activity in either scenario. This is corroborated by analysis undertaken by the Yorkshire Ambulance Service on behalf of the commissioners showing that there is no material difference in average journey time in either scenario. • Access to CRH from the motorway and Huddersfield is set to improve by 2021, with a significant investment in Halifax to Huddersfield A629 Corridor Improvements planned as part of a £1.4bn programme of transport improvements for West Yorkshire and York.

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
more integrated community based services – page 155.	
A key differentiator on clinical safety could be the volume of activity needed to maintain a safe service due to the ability of the staff to maintain the necessary skill sets. The ability of the HRI site to attract additional activity is considered superior to that at the Calderdale site and therefore could be argued clinical safety and therefore patient outcomes would be better at HRI than at Calderdale – page 157.	• A more comprehensive analysis of activity drift to other providers based on patient travel time analysis has been undertaken. This shows that there is no material difference in the volumes of activity in either scenario.
Estate Development Costs (PFI and non-PFI) will be higher at Calderdale and this does differentiate the two sites: The majority of the Calderdale site is subject to a PFI Agreement. However, should the Trust be able to undertake non PFI works, the site constraints mean that any capital cost at Calderdale could be higher than for corresponding works at Huddersfield – page 157.	• A more comprehensive assessment of the capital costs at Calderdale has been undertaken by a third party – Lendlease Consulting Ltd. These cost estimates are still subject to a number of assumptions however including reaching agreements with the PFI provider.
Implementation and double running costs will be higher at Calderdale and this does differentiate the two sites: The lack of flexibility of the PFI contract, associated costs and the time taken may well mean the relocation of activity to HRI may incur less double running costs over a shorter period of time than retaining activity at Calderdale. The Trust have a proven track record of being able to deliver capital projects at HRI using traditional procurement routes or P21+ much faster than has been the case through the PFI arrangement at Calderdale – page 157.	• Double running costs identified by divisions have shown no significant difference between the two site options. • CRH as the unplanned care site provides an opportunity to secure capital finance if capital funding is not available through the Department of Health.
Site constraint and limited land availability at CRH will limit long term sustainability and future service development this does differentiate the two sites: A significant increase in activity at Calderdale without the acquisition of further land will severely limit the	• Although the Calderdale site is more constrained in terms of space than Huddersfield, there are options to significantly increase clinical capacity on the site. Options include; ○ Exploration of use of retained estate from the current CHFT build;

OBC Rationale	5 Year Strategic Plan Response (i.e., what is different now and why?)
Trust to develop services to meet future needs of the population. Reduction in activity on the HRI site and as a result the sell-off of the majority of the current HRI footprint will severely limit the ability to develop services in the future. Selecting Calderdale as a primary site may therefore seriously impair the ability of the Trust to deliver comprehensive long term services due to the restrictions of the estates provision – page 158.	○ Use of Dryclough Close (estate on the CRH site owned outright by CHFT); ○ Increasing the number of vertical stories on the new build; ○ Multi-story car park development; and ○ Development on adjoining land. • These options will be appraised in conjunction with a review of opportunities to use Trust space elsewhere.



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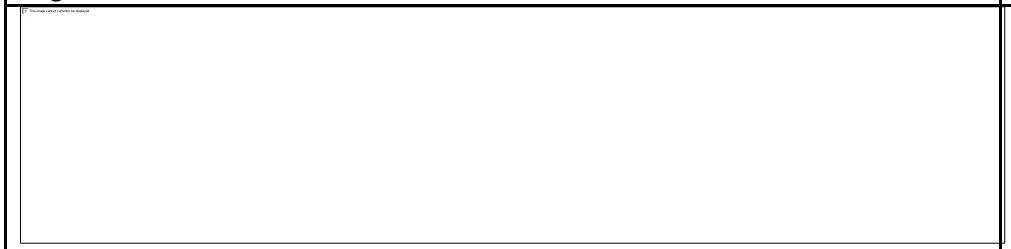
£m (Nominal)	Strategic initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
IM&T	22.9	22.9	22.9
Estates	4.3	213	280
Equipment	4	4	4
Other (including backlog)	124.8	124.8	47.9
Total	**156**	**364.7**	**354.8**



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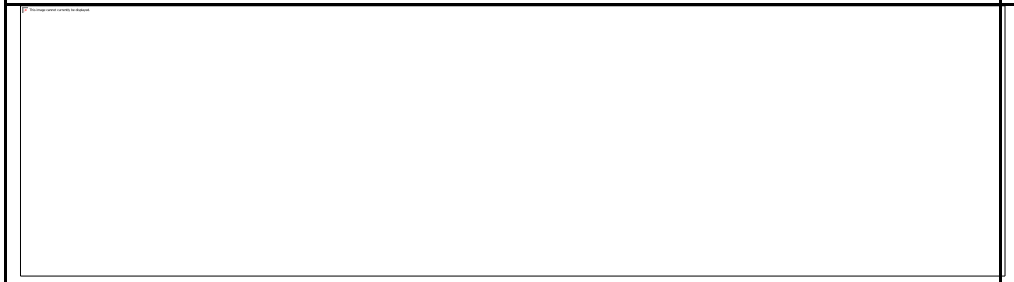
£m (Nominal)	Strategic initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
FY22 Do Nothing Surplus/ (Deficit)	**(31.2)**	**(31.2)**	**(31.2)**
Depreciation	(3.3)	(7.8)	(3.0)
Capital Loan Interest	(2.0)	(6.5)	(6.3)
PDC	0.7	1.5	4.8
Working capital interest	0.9	0.3	0.8
Strategic savings	7.4	7.4	7.4
Reconfiguration savings	—	14.7	18.0
FY22 Surplus / (Deficit)	**(27.5)**	**(21.6)**	**(9.5)**



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FY22 (Y5) £m (Nominal)	Strategic Initiatives savings	HRI as site for unplanned care	CRH as site for unplanned care
CIP	9.3	9.3	9.3
QIPP	2.4	2.4	2.4
Strategic savings	7.4	7.4	7.4
Reconfiguration savings	0	14.7	18.0
Total	**19.1**	**33.8**	**37.1**